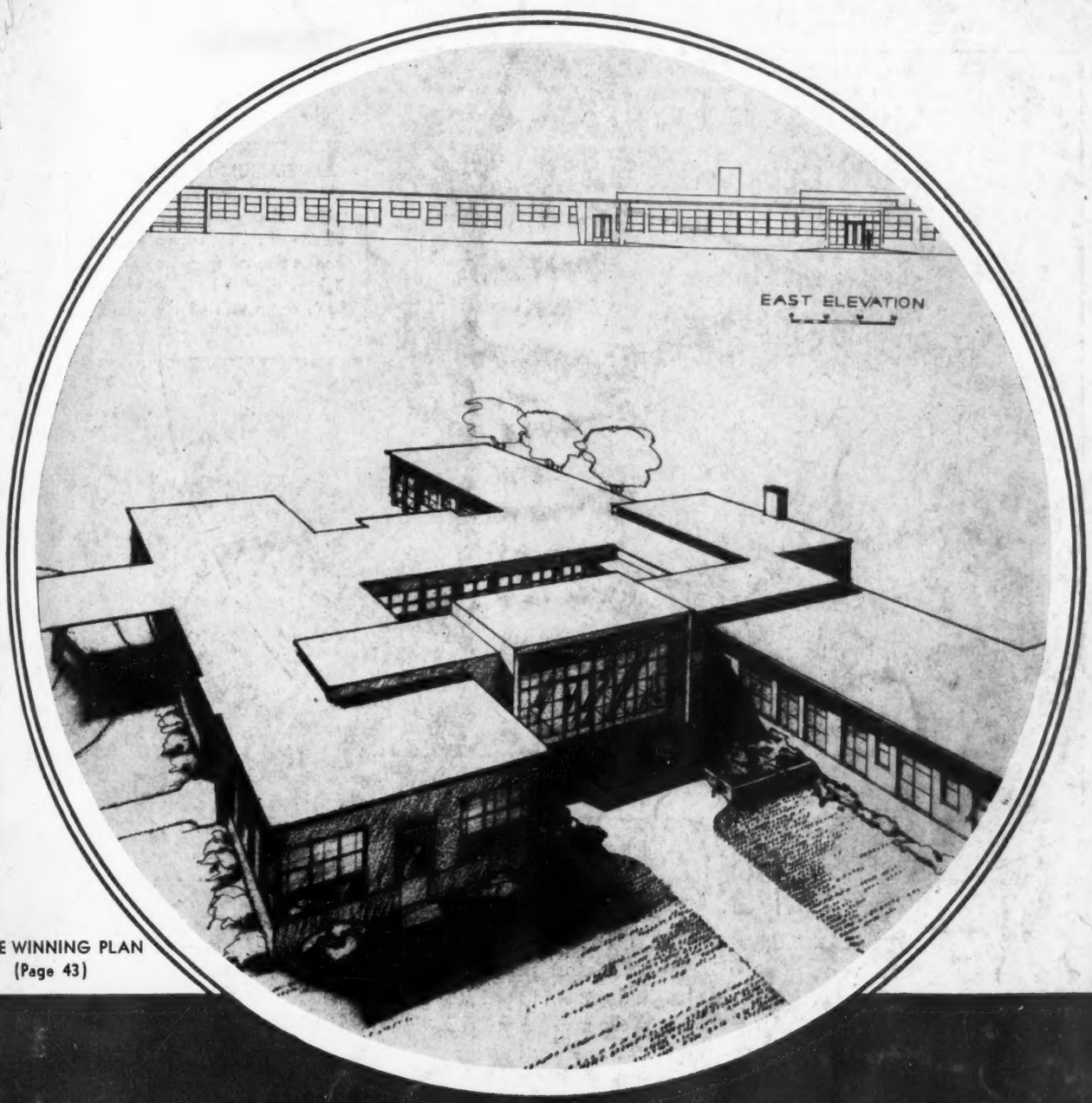

PRIZE WINNING PLAN
(Page 43)

the MODERN HOSPITAL

VOLUME 64 APRIL 1945 NUMBER 4

PLANETARIUM PROJECTOR . . . a remarkable optical device developed by Zeiss . . . which exhibits impressively, and with the full illusion of reality, movements of the heavenly bodies through space and time . . . its rays of light projecting stars and planets on an overhead dome with all the fidelity of a photographic lens.

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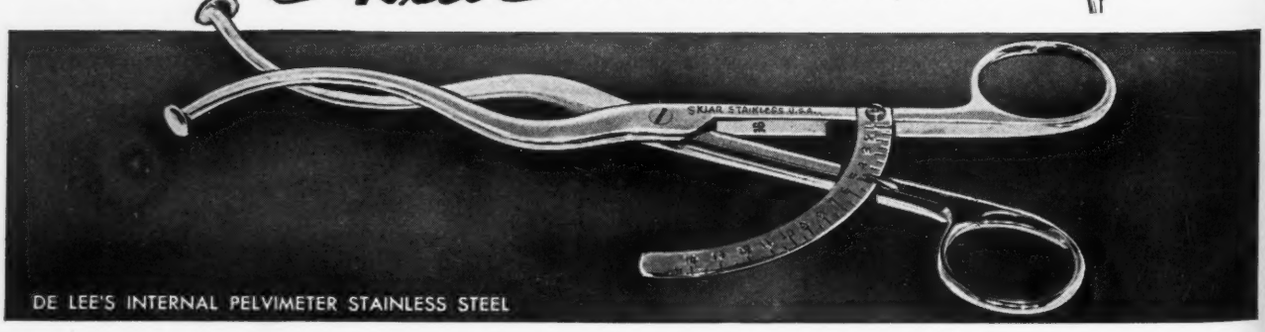
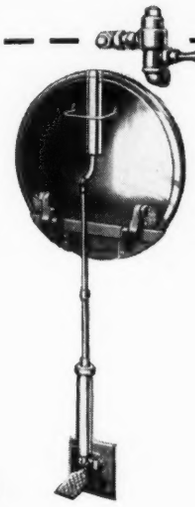


DE LEE'S INTERNAL PELVIMETER STAINLESS STEEL

ORBIT Alleviates Bedpan Drudgery . . . Helps Solve the Nurse Shortage



ORBIT

Built-In and Free-Standing Washers

with or without

Steam Sterilizing Attachment

With the ORBIT Bedpan Washer — either built-in or free-standing model — bedpans are automatically emptied and washed in less than one minute. Where individual sterilizing of each bedpan is desired, the washer may be had with Steam Sterilizing Attachment and control valve.

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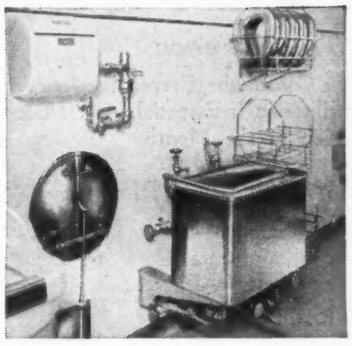

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AS a saver of nurses' time, particularly when serving large wards, most hospitals prefer the ORBIT 5-Pan Sterilizer. After a pan is washed in the ORBIT Washer, the nurse simply places it in a rack in the 5-Pan Sterilizer and goes about her work. When the steam valve is turned on, after five pans have accumulated, the pans are completely sterilized without further attention. Extra racks make it possible always to have five to ten sterilized bedpans available for use.

Write for descriptive literature. Our Engineering Department will be glad to help you solve your sterilizing problems—Sterilizers for Surgery, including central sterilizing installations—and to aid you and your architects in the planning stage.

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CONTENTS

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Lilly blood processing

PASSES

Two Million Mark

AN OCCASION of major proportions was observed early in February when Eli Lilly and Company completed processing into plasma the two millionth pint of blood. Blood comes to the Lilly Laboratories from Red Cross donor centers in Atlanta, Chicago, Cincinnati, Columbus, Indianapolis, Louisville, Milwaukee, and St. Louis. Mobile bleeding units operate out of all these centers to accommodate donors in the smaller surrounding cities and towns. Blood is sent from donor centers daily in insulated refrigerator boxes and reaches the processing plant by overnight express.

Plasma is employed to combat shock which so often accompanies battle injuries. Various substitute fluids have been suggested from time to time, but human plasma is most satisfactory. Dried plasma has the advantages of completeness from the physiological standpoint, stability, ease of transportation in large quantities, and rapidity with which the solution can be prepared. Every package of blood plasma processed by Eli Lilly and Company is supplied to the Government at exact cost of production. Plasma prepared by this Company is not available for civilian needs.

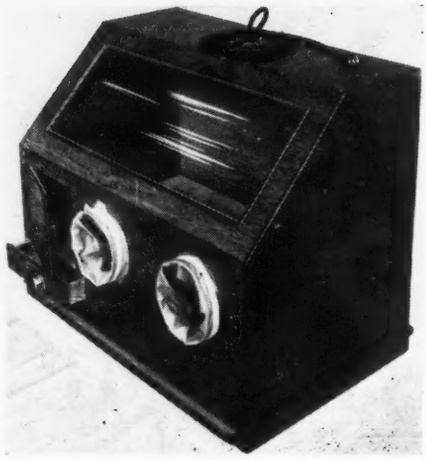
Eli Lilly and Company, Indianapolis 6, Indiana, U. S. A.

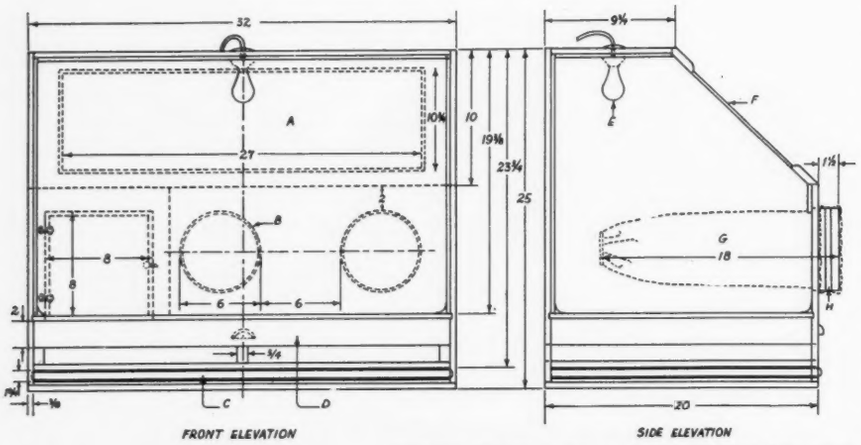
THE ROVING REPORTER

The Army Improvises

Those fascinating improvisations that physicians and hospital folk rig up for field hospital and first-aid use in the jungle or the mud or the desert sand make wonderful reading but most of them are mere primitive substitutes for the real McCoy in equipment in everyday use on the home front.

But Army hospitals under a fixed roof and on home soil show ingenuity as well. Take this glove powder box worked out at Letterman General Hospital, San Francisco, by Lt. Col. Russel H. Patterson, Maj. Frederick M. Anderson and Capt. George T. Aitken. When the surgical team powders its gloves, no powder dust settles on other objects in the room.





Courtesy: Bulletin of the U. S. Army Medical Department.

A, glass windows; B, metal sleeve; C, pull-out drawer; D, drawer; E, electric light; F, glass window; G, sleeve; H, tape to hold sleeve.

Made of plywood with all seams doubly overlapped to prevent sifting of powder through crevices, the box has a large drawer in the lower part that can be used for wrapping the gloves.

Sleeves are made of impregnated silk from the canopies of old oxygen tents or from ordinary oiled silk.

In John's Honor

John Fremgen took a hospital job on Dec. 8, 1894. He drove the horse hitched to the ambulance that bore the name of St. Catherine's Hospital in Brooklyn, N. Y.

Fifty years have passed and John is still at St. Catherine's working as a receiving clerk. On a recent Sunday John sat down to a testimonial dinner in his honor attended by 150 persons including the hospital chaplains, the religious, the doctors and nurses and the other personnel. There were music, humor, stories, speeches and even a poem honoring John written by Sister M. Benita, O.P.

Among the speeches of praise and reminiscence was one by Dr. William Meagher of the hospital staff who recounted John Fremgen's quiet guidance of the young doctors who rode his ambulance. None of them feared to go out on an ambulance call if John was along to help.

On one occasion a new doctor was called on an ambulance case and found a man who he thought was in a coma. The doctor hesitated and said to John: "This man is in a coma but what type of coma?" John answered very quietly: "Doctor, it's a D.O.A. viz.; let's go home."

Sister M. Suitbertha, R.N., the superintendent, reports that John received many presents at the dinner in addition to the vocal tributes.

Books 3 and 4

Quite a number of people are happier since Rochester General Hospital decided to supply maternity patients with a new service.

The idea came from the O.P.A. rationing board in Rochester, N. Y., members of which were troubled to see new mothers climbing the long stairs to the board's offices with 10 day old babies in their arms under the impression that they had to exhibit the infant in order to get the ration books to which he is entitled. Too, it appeared that new fathers would frequently sprint from the hospital to the ration board as soon as their offspring had been delivered to apply for the books.

The hospital uses its aide service for filling out the application forms. An aide visits the maternity building twice each week to get the names of new applicants; the forms are sent to the rationing board which, in turn, puts Books 3 and 4 in the mails so that they arrive at the home at about the same time the mother and child are welcomed there.

The Dangerous Age

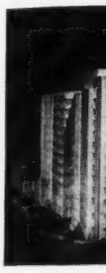
The dangerous age in the life of a student nurse is in the preclinical period. Casualties at that time are high. To reduce turnover among newly accepted students, Kentucky Baptist Hospital, Louisville, has developed a new screening procedure to use on applicants.

Those girls who meet the admission requirements of the school are invited to visit the hospital in groups of six for a three day period. They get a tour of the hospital, attend classes, have their physical examinations, occupy beds in the dormitories and take part in the school's activities. During these three days they are carefully observed and individually interviewed. As a result about 40 per cent of them are eliminated. As might be imagined there are many fewer drop-outs during the probationary period.

Tribute to Graduates

Nursing school graduations run pretty much according to the traditional pattern and in these days of accelerated curriculums there isn't time to develop the more democratic, pupil participation, activity type of program now being successfully developed in many high schools and junior colleges. After the war, a change in the commencement pattern deserves consideration.

Graduation ceremonies are the climax to effort, hard work and high hopes,



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however, and should not be slighted regardless of extra war-time demands on the administration. Don't you like the idea of the mother-daughter banquet which was a part of the recently observed forty-fifth annual commencement at Miami Valley Hospital School of Nursing, Dayton, Ohio? Each of the 21 graduates had her mother or foster mother as guest and the event went off with dignity and dispatch.

Each graduate received a beautiful volume of the New Testament bound in white leather and each mother wore a gift corsage. There were musical selections and mimeographed programs. The banquet was a fitting prelude to the formal commencement exercises held on the evening of Washington's Birthday anniversary.

Take a Tip From Florida

Either inter-hospital or intra-hospital professional or occupational groups could take a tip from the local executive secretaries of tuberculosis associations in Florida.

Fourteen of these secretaries have organized a book-of-the-month club for themselves. The Florida Tuberculosis Association has purchased 14 books from a list submitted by the secretaries and has deposited them with the library of the state board of health, which assumes the responsibility of listing, routing and financing the monthly shipment.

Each member's book arrives at his desk on the first of the month and must be returned in time to be reshipped to the next member of the book club by the first of the following month.

Selections are not entirely concerned with tuberculosis or its control. The theory behind the book-of-the-month club is that each member should know about the work of the social worker, the public health nurse, the newspaper editor and of those in other related fields so that better coordination of effort will result.

How Soldiers Feel About It

A Missouri hospital administrator received a letter from the South Pacific and he immediately saw its potentialities in nurse recruitment. Ray F. McCarthy of the Blue Cross Service in St. Louis heard about it and had it photographed on blue notepaper so that it could be enclosed in all mail going out from subscriber hospitals for a period of one month.

Here is the letter but if you want it in the author's script, write to Ray McCarthy, Continental Building, St. Louis, for a copy:

Somewhere in the South Pacific
Dear Dad:

The bullet didn't hurt nearly as much as knowing that the folks back home are letting us down.

We're short of nurses but won't get any more until Sis and other girls like her sign up as student nurses and release a graduate nurse to come out here.

You've never failed me, Dad, and I know you won't take the attitude that some parents do about nursing as a profession for their daughters. This is the darndest, swellest thing that any girl could do for her country right now. I told my buddies you would not let me down.

Love,
Jim.

Something New in Chaplains

Don't expect to be addressed in a hearty baritone if you ask to see the chaplain at Bethany Hospital, Kansas City, Kan. You'll get a warm greeting from the chaplain, whether you are visitor, patient or employe, but the voice falls in the feminine register for Mrs. Ethel M. Rice is the new chaplain's name.

Mrs. Rice makes friends readily as you can imagine when you find that she has just come from the post of counselor and hostess to the student body of Kansas Wesleyan University at Salina. Mrs. Rice has had teaching, homemaking and business experience but her

most important work has been as a teacher with religious groups, a church visitor and a lay delegate.

The patients and their often distressed relatives respond immediately to Mrs. Rice's reassuring warmth and, by reason of her sex, she has been able to establish close rapport with student and graduate nurses.

First Aid on Four Feet

On the Eastern front many of the stretcher bearers have four legs, the better to speed the wounded to the advanced medical posts and evacuation hospitals.

These dogs of the U.S.S.R. are attached to medical battalions and in summer are harnessed to wheeled litters and in winter to sleighs. The Red Army finds that this practice has saved many men from being wounded a second time as sometimes happens when they are being carried off the field by orderlies or human stretcher bearers. The dogs bring in the wounded and return to the battlefield with munitions and food, writes Antonina Shapovalova.

The dogs are trained to hunt for wounded in the woods and bushes. Each dog has a stick tied around his neck; if he finds a wounded man he grabs the stick in his mouth and dashes back to the advanced medical post. This is a signal for a first-aid man to follow the dog back to the wounded soldier.

Medical service dogs have first-aid kits fastened to their bodies. If a wounded man is in condition to dress his own wounds, he makes use of the kit.

In Russia civilians, many of them little boys, raise and train the dogs, except for the specific training the dogs get when they are inducted into the Red Army. The Society for Chemical and Air Defense began to breed dogs for the army back in 1925 but it soon realized that it is easier and better to have the pups bred and raised in private homes. Each dog owner promises the army at least six pups a year. The society provides funds for their feeding.

Good Attendant Defined

"A friend with a sense of responsibility" is the definition of a good hospital attendant given in that splendid little magazine, the *Attendant,* which is a part of the mental hygiene program of Civilian Public Service.

Thirteen suggestions to attendants in dealing with mental patients given in the January issue of the *Attendant* are also valuable to nurses, nurse's aides and other hospital workers in dealing with general hospital patients. They are as follows:

1. Be a friend, not a "buddy," a counselor, not a drill sergeant, to your patients.
2. Suggestion is often much more effective than are orders.
3. Learn to listen well and often, but with discrimination.
4. Make your directions clear and on the patient's level of understanding.
5. Develop a passion for finding ways of motivating patients to want to do what they ought to do.
6. Be honest and truthful so that the patient can rely on you. Never use a promise or a threat which you are not prepared and able to carry out.
7. Try to know your patient and be willing to start with him where he is.
8. Respect your patient as a person; don't talk about him in his hearing or disregard his likes and needs.
9. Spread your attentions over the entire ward, including those who do not demand attention.
10. Compliment patients for performing up to *their* ability, not just to *your* standard.
11. Work along with your patients; show them you know how as you show them how.
12. Conceal extreme emotional responses from your patients, such as fear, over-sympathy, disgust, irritability, worry.
13. Don't discuss your personal affairs and troubles with patients.

READER OPINION

The Lady Protests

Sirs:

I am a little late in reading the January issue of The MODERN HOSPITAL, having just discovered it this noon in the hospital library.

The news imparted by one little article in it perturbed me to the extent of causing me to write this letter. My anger is not directed toward you, of course, since you only imparted the facts. That is the trouble in this whole situation; one doesn't know to whom to direct one's crusade. I am starting with you and perhaps you can direct me into the proper channel.

The offending article, or rather the offending news which the article imparts, is on page 124 of the January issue. It states that inquiries are being made of M.A.C. officers to determine whether or not they are desirous of "returning" to hospital administration after the war. (Why "return" since not a one that I have met in the Army was in hospital work before he joined the Army?)

Now, let me state why this article has so infuriated me. I am a pharmacist, have been for twenty years and I am a medical technologist and an x-ray technician. For fourteen years I took an active hand with the administrative, as well as the educational and scientific, problems of a 125 bed hospital. In the Army I am a T/4. Some pharmacists don't even get that. Most cooks do. Well, that is the Army and we have to make the best of it.

However, now, when according to the article, these former shoe clerks, lawyers and what not are being encouraged to usurp the field in which we naturally feel our future lies when the present conflict is over—well, what would you say?

I'm all for young people getting ahead, but are our education and experience to be completely scrapped? Our profession has been and is being exploited and now our future is being cut off.

Do you see why I want to be heard? Will you help me?

A.D.B.

There will be a substantial expansion of hospital facilities as soon as the war controls are relaxed. This will mean a large number of civilian hospitals designed to meet more adequately the needs of the whole population.

Recently, Surgeon General Thomas Parran estimated that at least 2400 health centers with some hospital facilities would be needed for rural areas. In addition, most of the existing urban hospitals will need to be increased to provide a better standard of hospital care to present categories of patients and to offer care in new fields which have hitherto been neglected, particularly care of patients with chronic diseases and those who are convalescent.

Above all this, there is projected an enormous expansion of Veterans Administration hospitals to provide the care that will be needed by 15,000,000 people from our armed forces.

On the basis of these facts it would appear that you would have no difficulty in finding a better position following the war than the one you had.

Most of the former shoe clerks in the M.A.C. will probably not want to continue. If they do, they will certainly have to take additional training.—ED.

Scholar's Complaint

Sirs:

You may remember my perennial complaint that hospital writers do not quote authority frequently or completely enough. In writing on a certain subject you seldom find reference to the work of others on the same subject (a good example is the stuff on chronic disease, including the editorial in the current number of *Hospitals*). You ought to make it a rule for every author to provide bibliographic references wherever these can be helpful to the reader.

I am prompted to write to you about this because of the article "How to Pay the Radiologist?" which just came to my desk. The author would have done well to have given a sentence or more to the "Manual of Desirable Standards for Hospital Radiological Departments" issued by the American College of Radiology, 540 North Michigan Avenue, Chicago.

E. M. Bluestone, M.D.
Director

Montefiore Hospital
New York City

That Word "Neuropsychiatry"

Sirs:

I hope that you won't use the word "neuropsychiatry." Neurology and psychiatry are not very closely related and I think that really first-class neurologists know it and I'm sure the first-class psychiatrists feel it. A merging of the two words into neuropsychiatry implies an intimacy that is more apparent than real.

John R. Stone
Business Manager

Menninger Clinic
Topeka, Kan.

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

That Nursing Shortage

Question: I should like to know how we can get registered nurses for our 40 bed hospital. We shall soon have three nurses going into service. I am now filling three positions (among them that of the operating nurse who has left) and many more. We have two registered nurses on night duty, three including myself, and we have a good supply of trained aides who really have saved our lives here. We pay our hourly registered nurses 65 cents an hour plus meals.—E.S., Iowa.

ANSWER: The questioner has asked something to which many of us would like to have the answer. In the early stages of the present acute nurse shortage, we took a good bit of comfort in the fact that we could train lay persons —nursemaids, orderlies and the like—to relieve the nursing situation. However, today most of us find that this lay help is just as difficult to find as are professional nurses. The questioner, therefore, is fortunate indeed to have a "good supply" of her own trained aides.

We suggest that full advantage be taken of the lay persons available by giving them training as substitute workers for the nursing staff. We all know what has been accomplished in military nursing by the use of corpsmen and trained lay persons, also that our civilian hospitals depend to a large extent on lay persons to augment nursing staffs.

The questioner might find it possible to take advantage of the Red Cross volunteer nurse's aide program. Perhaps, she has not done everything possible in the way of canvassing her community for bringing inactive nurses back into service. It appears that the salary mentioned, which is equivalent to $2000 per year, is reasonably adequate.

Great credit is due the nurse administrator in the small hospital who is able and willing to carry on, not only as the administrator but as bookkeeper, registration clerk, operating room supervisor, laboratory technician, cook and in many other emergency assignments. Her willingness to bear up under such conditions in these critical times most certainly places her among the heroines of the war period.—ROBERT E. NEFF.

Improving Working Conditions

Question: How can we continue with plans for improving working conditions, such as hours, outside living quarters, vacations, pensions and health plans, for our employes?—R.C.W., Calif.

ANSWER: There are a number of things that can be done now, even in a small hospital. Someone in the institution should make personnel administration his special field of interest. Often this must be the administrator himself but sometimes the dietitian, the housekeeper, the engineer, the purchasing agent, the pharmacist or some other department head may show a special interest in and aptitude for personnel administration.

Whoever is to assume the major responsibility for personnel administration should take special preparation for this responsibility. The first thing is to read widely in the field of personnel administration. Among many general books that can be especially recommended are:

Tead, Ordway, and Metcalf, Henry C.: Personnel Administration, Its Principles and Practice. New York City: McGraw-Hill Book Company, Third Edition, 1933. Pp. 519. $4.

Scott, Clothier, Mathewson and Spriegel: Personnel Management. New York City: McGraw-Hill Book Company, Third Edition, 1941. Pp. 589. $4.

Yoder, Dale: Personnel and Labor Relations. New York City: Prentice-Hall, Inc., 1938. Pp. 644. $5.35.

A great deal of fine material on personnel management appears in the hospital journals.

The administrator or director of personnel should consider the possibility of enrolling in an afternoon or evening course in personnel management at some near-by college or university, if possible. He should plan to attend one of the institutes on personnel management that will be given this year by the American Hospital Association.

On the basis of this study, the administrator should formulate a schedule of improvements in personnel administration that he wishes to make in his hospital. These will include such subjects as selection of personnel, placement of personnel, supervision of training programs, safety work, insurance, welfare and annuity programs for employes, handling of grievances, promotion and transfer policies, health service plans, maintenance of personnel records, studies of fatigue elimination, direction of financial aids to employes (credit unions and the like) and service activities (recreation, housing, clubs, legal advice and personnel counseling). Job descriptions, job and personal evaluation, salary schedules, incentive systems and similar matters will be important. A labor-management committee may be used to help work out the program.

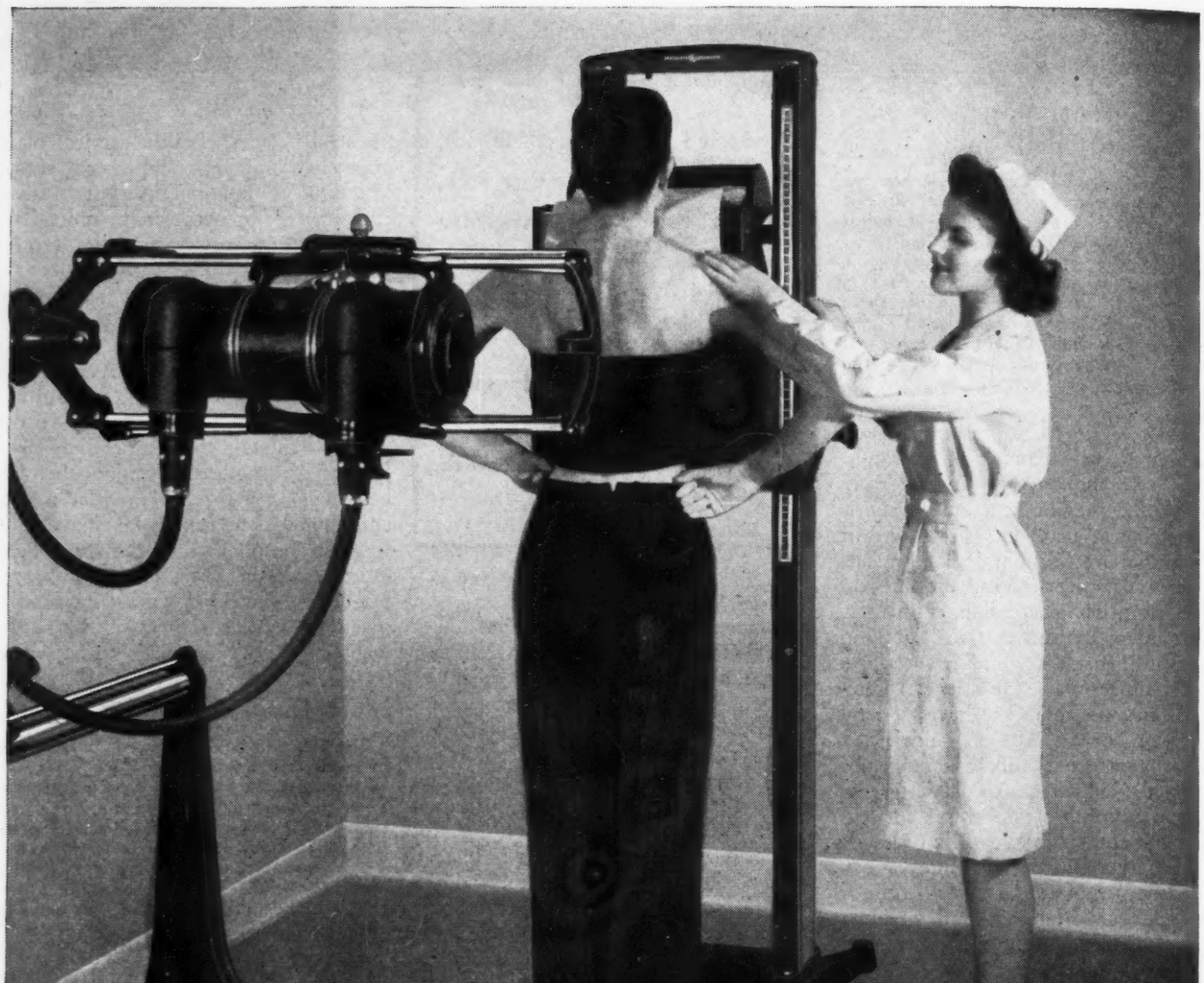
This schedule for improvements in personnel administration might then well be discussed with the board of trustees and appropriate action taken to adopt it as the hospital's own program. Some estimates of the cost of the various steps might be hazarded and consideration given to possible sources of the needed income.—A. B. M.

More Duties for Aides?

Question: In our hospital where one group of nurse's aides worked for three years, some of the aides feel that they have now reached a stage where they should be given more responsibility. The difficulty encountered here is that the aides do not come to the hospital on any two successive days and there is no continuity in their work. I should like to know how hospitals that have had this same experience are meeting the issue.—G.R.J., Ill.

ANSWER: If the nurse's aide has been recruited and trained by the individual hospital, the responsibility of further training to fit her for increased duties lies entirely in its hands. A goal of at least five hundred hours' continuous service within a period of time should be a requirement. If the aide has been trained by an outside organization, such as the American Red Cross, further training and responsibility should be arranged through it. No aide should be given extra responsibilities without adequate and supervised training for them. To increase one aide's responsibilities without training and not another's would set up an undesirable precedent.

It is difficult to arrange a program requiring two successive days' service in a week but a satisfactory arrangement can be made by staggering one assignment for the week among three aides. The greatest amount of dependability for the hospital and satisfaction for the aide is obtained when she has a definite floor and day assignment for each day of service. Undependability is more often the result of inadequate planning by the hospital and lack of interest and effort on the part of the personnel. If the hospital makes the aide feel that she is needed and appreciated, she will give all of the service she can.—KATHRYN S. WALSH.



To Preclude Tuberculosis Infection in the General Hospital

How many cases of pulmonary tuberculosis are unknowingly being admitted by general hospitals, despite constant vigilance that aims to detect them?

That a hospital may fail to detect this condition in 2 to 4 percent of patients admitted, and thus expose other patients (as well as the institution's personnel) to tuberculous infection, has been shown by a number of carefully conducted surveys. It is in light of these surveys that authorities have sounded warnings against this existing danger.

Some hospitals have heeded these warnings, and today are routinely obtaining a chest radiograph of each and every entering patient, as well as periodically of the hospital personnel. They have been convinced that a most logical place to begin case finding for tuberculosis in the general population is among admissions to their wards and dispensaries.

With a G-E Photo-Roentgen Unit, which utilizes low-cost, miniature-size films, your hospital too will find this procedure economically feasible. Let us help you plan an installation best suited to your particular needs. Write today for Pub. No. J44.

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LOOKING FORWARD

Convention by Mail

THE New England Hospital Assembly has asked the speakers who would have addressed its canceled convention to send in their speeches anyway. These will be printed and circulated to the members, thus giving them some of the benefits of the meeting while observing O.D.T.'s rules.

This is an idea that many other groups might well consider. It could be elaborated a bit. Each paper, for example, might be submitted to a member of the association for him to append a comment. In this way some of the benefits of the discussion periods would be passed on.

In this conventionless period, of course, the hospital magazines must do an even better job of keeping administrators informed of the new developments. In a sense this is an advantage because the careful editing of a well-run magazine avoids the repetition of the well-known that is almost unavoidable in any convention program. Probably, a hospital administrator or department head will actually gain more in ideas by spending the time it would have taken to attend a convention in more intensive reading of his favorite professional magazines.

Crippling Medical Education

A DEVASTATING attack on the Army's policy toward medical education has been made by Dr. Evarts A. Graham in a recent issue of the *Saturday Evening Post*. Doctor Graham, in addition to being a past president of the American College of Surgeons and a distinguished professor at Washington University School of Medicine in St. Louis, was himself a major in charge of an evacuation hospital in World War I and a member of a committee appointed by the Secretary of War in 1942 to study the medical needs of the Army.

Aiming particularly at the 9-9-9 plan, Doctor Graham says that one might suppose that a plan of graduate medical education through longer residencies "that has been demonstrated to be effective in the preparation of medical officers would be allowed to continue to supply replacements of the same caliber. But instead it has been scrapped by the War and Navy departments."

Doctor Graham lays this unwise action to a commendable desire to avoid "too little and too late" plus a considerable amount of hysterical reaction to an emergency. Too blind a reliance has been placed on the magic of numbers, thinks Doctor Graham. Because the tables of organization said 6.5 doctors were needed per thousand men, the armed forces demanded those numbers, even though graduate education were thereby crippled. The general philosophy seems to be, says this noted educator, "Better have a lot of poorly trained medical officers than fewer well-trained ones." The British, Australian and Canadian armies are organized on a basis requiring only a little more than half the number of medical officers considered necessary by our Army, Doctor Graham points out.

If all of the doctors in the Army were fully occupied in the care of soldiers, sailors and other members of the armed forces, the situation would be felt by most authorities to be unavoidable. But that is not the case with many medical officers who have completed their indoctrination and then have had little or nothing to do.

Doctor Graham's plea is not primarily for the benefit of civilians, although he does point out the great lack of care at home; it is primarily to maintain enough graduate medical education so that the Army and Navy may have properly prepared doctors, particularly surgeons. Were he a psychiatrist he probably would make an equally eloquent plea for adequate training for this vitally important group of specialists.

Care for Psychiatric Patients

ALL hospital people, regardless of the field in which they have been trained, are warmly invited to participate in the competition that is announced on page 64A of this issue. This is a $1000 essay competition on the subject of "A Plan for Improving Hospital Treatment of Psychiatric Patients."

Today there are more than 650,000 beds listed in the A.M.A. register under the "nervous and mental" cate-

gory. Undoubtedly there are additional thousands of beds in certain other hospitals classified as "general."

To date, however, the results that ought to have been achieved have largely eluded us. In spite of the tremendous outlays for buildings and equipment and large total budgets for maintenance, we do not spend enough money or have enough personnel or maintain high enough standards to meet the needs of many patients.

It is the hope of The MODERN HOSPITAL that this competition may bring forward some excellent ideas for improvement. Furthermore, it is hoped thus to focus public and professional attention upon this problem.

Administrators of general hospitals and those who have responsibility for psychiatric institutions are invited to participate. The same invitation is extended to psychiatrists and psychologists, nurses, social workers, attendants, therapists, pupils in these fields, former patients, relatives of patients or anyone who is interested. A bibliography will be sent on request to The MODERN HOSPITAL.

Unexpected Dividends

WHEN the psychiatric hospitals of the United States asked the Selective Service System to assign conscientious objectors to work in these institutions, it was primarily to help in meeting the shortage of hands and feet.

However, many of these young men who are assigned to civilian public service are of unusual education, background and vision. As a result they have formulated the "Mental Hygiene Program of Civilian Public Service." In preparing the program they have obtained assistance from a group of outstanding psychiatrists and hospital administrators, namely, Dr. Earl D. Bond, Dr. Samuel W. Hamilton, Dr. James Lewald, Dr. George S. Stevenson and Dr. Charles A. Zeller, and from William Draper Lewis, director of the American Law Institute.

This program contains five points. First is publication of a monthly leaflet, the *Attendant,* to inform themselves about ideas, attitudes and methods of work in hospitals for the mentally ill. It contains articles by professional experts and by C.P.S. men.

The second point is legal research, including a review of all state and federal laws that govern the commitment and care of individuals held in custody because of mental illness or deficiency, and the preparation of model state statutes on this subject. "The needs and responsibilities of society will be considered, parallel with the need for protecting the rights and dignity of the individual."

Third in the program is an exchange of ideas and materials of help to C.P.S. men in their work, such as recreational programs, methods of handling overactive patients, bibliographies and useful articles.

A summary statement of conditions based on their experiences will be prepared in cooperation with hospital administrators, as the fourth project.

The fifth and final point is in the field of public education. It is described as "the preparation of ourselves and others with such a knowledge of the problems and scope of institutional service that we will be qualified to act as an intelligently vocal citizenry in helping to foster institutional development."

This program is officially sponsored by the National Committee for Mental Hygiene.

Although the number of men involved is small and a few of them are themselves considered "queer," this kind of approach to their work promises great good for future generations of patients in mental disease hospitals. What is needed more than anything else is a body of intelligent, informed and courageous citizens who will speak out boldly and clearly on behalf of better care of these patients. After the war, these conscientious objectors may form the nucleus for such groups.

An Acute Problem

THERE is something unclear, and even misleading, about the term "chronic" and we are therefore beginning to speak, more hopefully, of "long-term" illness as we plan for all patients these days. Much is being thought, spoken and written on this subject during these lively days of hospital history as we look into the hospital of the postwar world. The merits of the long-term patient, who may or may not be "chronically" ill, as compared with the short-term patient, who may or may not be acutely ill, are being debated vigorously in our council halls.

Communally-minded hospital executives who are taking recent developments in preventive and curative medicine into account and are responding to certain wholesome pressures are beginning to recognize a trend toward the fusion of both types of patient for the purposes of hospitalization so long as intensive need for scientific care in a hospital can be shown. Home care and custodial care lie on the periphery of the hospital in the new planning and both of them leave us free to obtain greater value out of our hospital beds for a greater number of clinically deserving people.

In this connection, a recent report from a great voluntary hospital in the East is of interest. Out of a large series of long-term patients, one third terminated fatally, two thirds were bedridden, one fourth were able to use wheelchairs from time to time, one sixth were incontinent, one seventh had to be fed by hand, one fourteenth had bedsore complications and one one hundredth had pathological fractures. About a thousand blood transfusions of various kinds were given during the course of a year and major surgery, like major problems in medicine, was never of the simple textbook variety. Every patient was a challenge to the medical scientist, who held his appointment on the basis of selective interest and who was willing to struggle patiently with Nature in her most perverted forms in order to win a partial or complete cure.

The "aged" problem has become young and the "chronic" problem has become acute. Postwar planners would do well to note such trends and build accordingly.

MARSHALL SHAFFER
NATHANIEL OWINGS
MIES VAN DER ROHE
ADDISON ERDMAN
F. G. CARTER, M.D.
GRAHAM DAVIS

THE JURY REPORTS

On three prize-winning designs and three honorable mentions in The Modern Hospital's Architectural Competition No. 2 for plans of a rural health center

ABOUT THE WINNERS

1

$1000

Samuel E. Lunden and Louis C. Dixon, both of Los Angeles, collaborated on the winning design for the health center.

Mr. Lunden is architect for the development of the postwar building program for two Los Angeles hospitals, Hospital of the Good Samaritan and Methodist Hospital of Southern California. The list of his accomplishments in his field include designing the Los Angeles Stock Exchange, Rancho La Brea Pit Museum for Los Angeles County and a number of elementary and high school buildings; serving as co-architect for the Doheny Memorial Library at the University of Southern California and consulting architect on the Allan Hancock Foundation for Biological Research at U.S.C. He has also been co-architect on various housing projects.

A graduate of M.I.T., Mr. Lunden went to France in 1921 as a member of Anne Morgan's Reconstruction Unit in Verdun.

He is the author of a book entitled "Community Development Through an Exposition for Los Angeles," which was published in 1944 by the Haynes Foundation of Los Angeles.

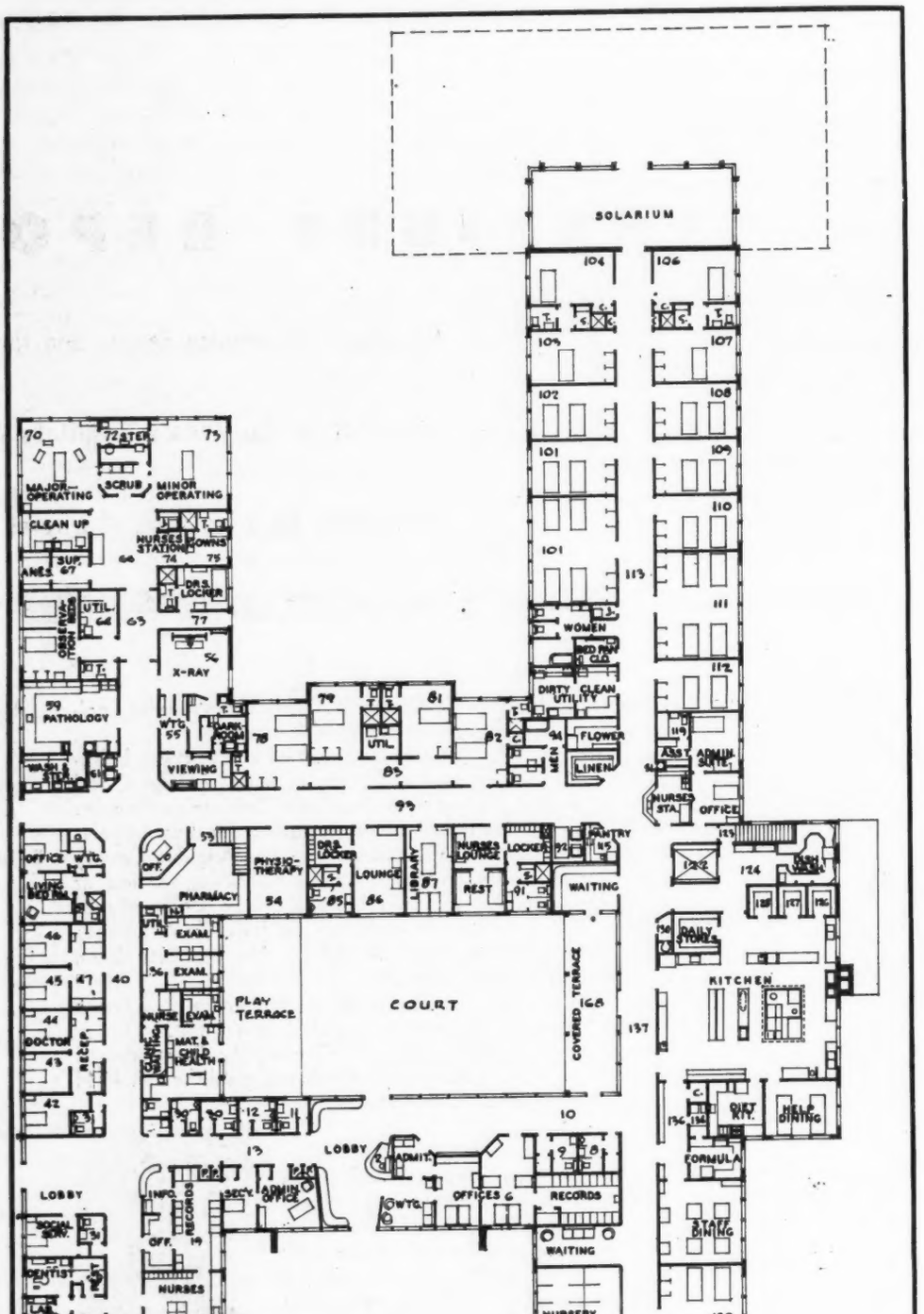
During these war years, Louis C. Dixon has been designer and architectural superintendent on war plants for Bendix, Hughes and North American aircraft companies and for Standard and Richfield oil companies. He has practiced as a licensed architect since January 1942 and reopened his own office in July 1944. At present, he reports, he is engaged in additions to a medical building; rebuilding of lumber yard buildings destroyed by fire; experimental design in connection with prefabricated shelters for the U. S. Marine Corps, and postwar hospital and residential research.

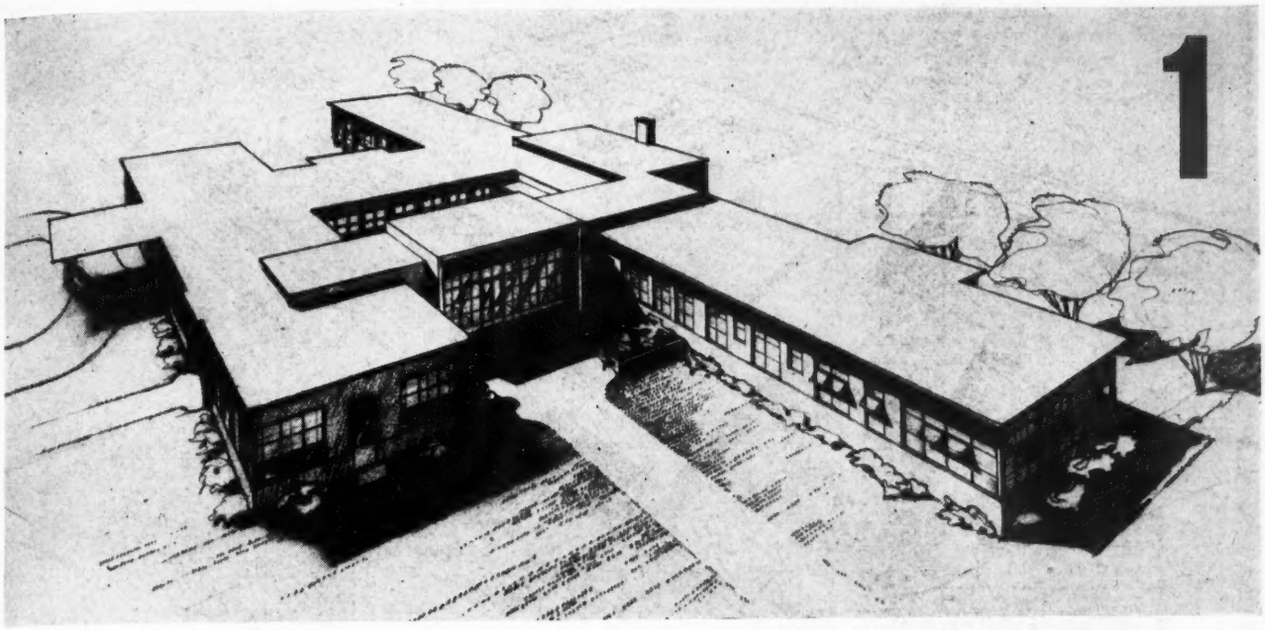
• THE ARCHITECTS' STATEMENT

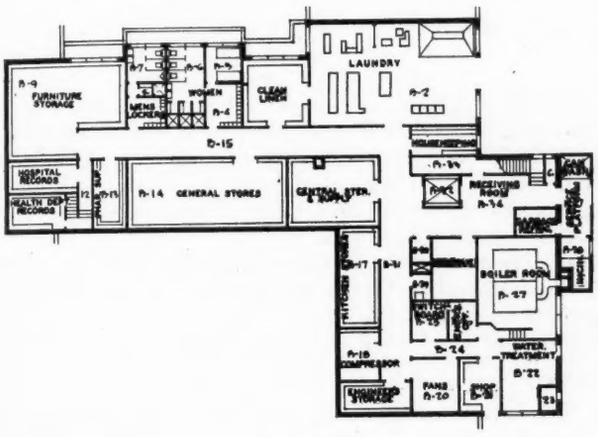
THE HEALTH CENTER is designed to serve a population of approximately 30,000 living within a radius of 15 miles. It is located in county territory between two large cities. The immediate community in which the health center is located is in unincorporated territory but has a population of approximately 3000 and is the largest of a number of small cells within the area to be served.

The people living within the over-all area are, for the greater part, unskilled and semiskilled laborers. They include workers on small farms and in dairies, as well as industrial workers who are employed in the adjoining miscellaneous industrial area of one of the adjacent cities. The population is a mixture of a number of races, including about a 10 per cent nonwhite population.

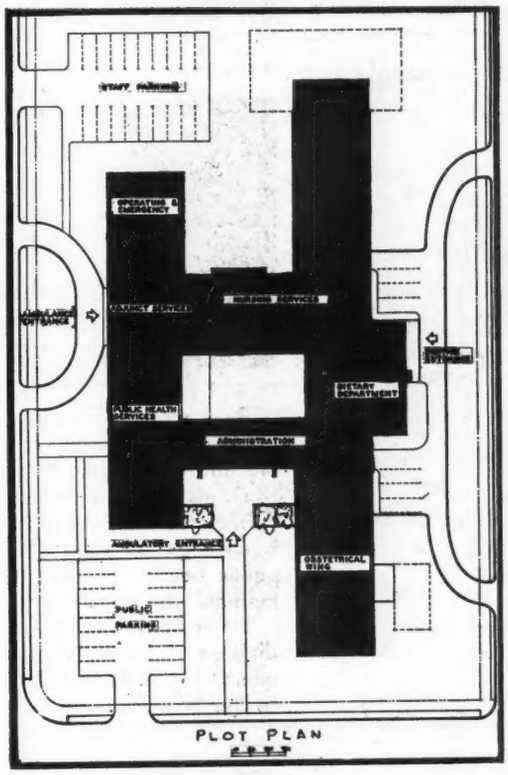
1


SOLARIUM
MAJOR OPERATING
SCRUB
MINOR OPERATING
CLEAN UP
NURSES STATION
DOWNS
ANES.
SUP.
DR'S LOCKER
UTIL.
OBSERVATION
X-RAY
PATHOLOGY
WTG
DARK ROOM
VIEWING
WOMEN
BED PAN CLO.
DIRTY UTILITY
CLEAN UTILITY
FLOWER
MEN
LINEN
ADMIN. SUITE
NURSES STA.
OFFICE
OFFICE
WTG.
LIVING
BED RM.
PHYSIO-THERAPY
DR'S LOCKER
LOUNGE
LIBRARY
NURSES LOUNGE
LOCKER
PANTRY
WAITING
REST
PHARMACY
EXAM.
PLAY TERRACE
COURT
COVERED TERRACE
DOCTOR
RECEP.
MAT. & CHILD HEALTH
DAILY STORES
KITCHEN
DIET KIT.
HELP DINING
FORMULA
STAFF DINING
LOBBY
ADMITT.
OFFICES
RECORDS
WAITING
INFO.
SECY.
ADMIN. OFFICE
OFF.
NURSES
SUPT. OF NURSES
SOCIAL SERV.
DENTIST
LAB.
SAN. ENG.
NURSERY
WORK RM.
SUSPECT
UTILITY
DOCTORS
SOLARIUM
CLEAN UP
SCRUB
DELIVERY
LABOR & EMERG. DEL.
STER.
FIRST FLOOR
SUMMER WINDS
WINTER WINDS
NORTH





BASEMENT



PLOT PLAN

The medical officer who acts as administrator of the hospital is the county representative in charge of the health service for this particular section of the county.

The site is located in the Southern California area, approximately 20 miles inland, at an elevation of 100 feet above sea level with the surrounding land sloping gently from the mountains to the sea.

• THE JURY'S STATEMENT

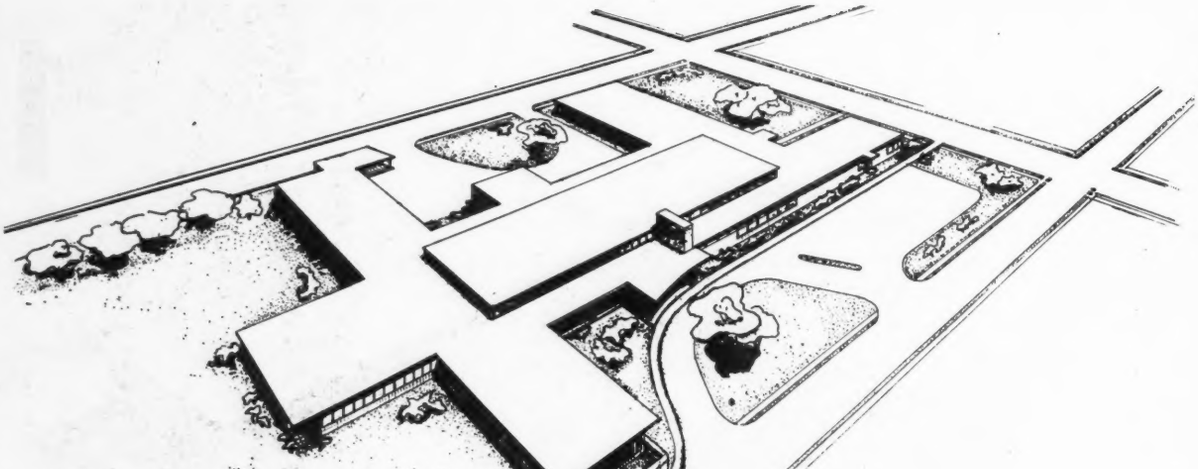
THIS PLAN IS WELL INTEGRATED with the various services of the hospital and the health center placed in proper relation to the scheme as a whole. The health department and the doctors' private offices are properly related to the adjunct diagnostic facilities. Adequate provision has been made for expansion to 60 beds. The orientation gives south, east or west exposure to all patients' rooms.

The detailed layout showing size, equipment and arrangement has been well handled in the majority of the rooms. However, the architects apparently overlooked the necessity of lavatories in each two or four bed room and in doctors' private offices.

Although the architects have achieved segregation of the maternity section, this segregation perhaps goes too far with the kitchen and dining rooms placed between the maternity and the other nursing areas, thus making a long run for the nurses at night and not permitting flexibility in the number of beds assigned to the maternity department. This criticism is offset, in part, by the ease of food distribution from a central spot.

The plan is economically developed with 476,000 cubic feet, although adequate space is provided.

It is believed by the jury that, in spite of their simplicity and economy, the elevations require much further study to achieve an exterior design of distinction.



PERSPECTIVE

2
$750

Roslyn Ittelson (Lindheim), collaborator with Dr. Leonard Greenburg on the plan awarded second honors, is starting a successful career early. Born in 1921 in New York City, she first attended Radcliffe College and then took her bachelor of architecture degree at Columbia School of Architecture in February 1944. She was awarded the Langley Fellowship for 1944 by the A.I.A.

The contestant assisted Henry S. Churchill in the preparation of a book on "Neighborhood Design and Control," published by the National Committee on Housing.

Mrs. Lindheim's husband is now with the armed forces in Burma.

Dr. Leonard Greenburg, New York City, has three degrees after his name: C.E. from Columbia University School of Mines, Engineering and Chemistry; Ph.D. in public health from Yale University, and M.D. also from Yale School of Medicine. An engineer in the U. S. Public Health Service from 1918 to 1932, Doctor Greenburg has been engaged since 1918 in numerous investigations in the field of public health. He has contributed a number of scientific articles on medical and engineering subjects.

Since 1935 Doctor Greenburg has been executive director of the division of industrial hygiene of the New York State Labor Department. He is also consultant to the U. S. Department of Labor and to the War Production Board.

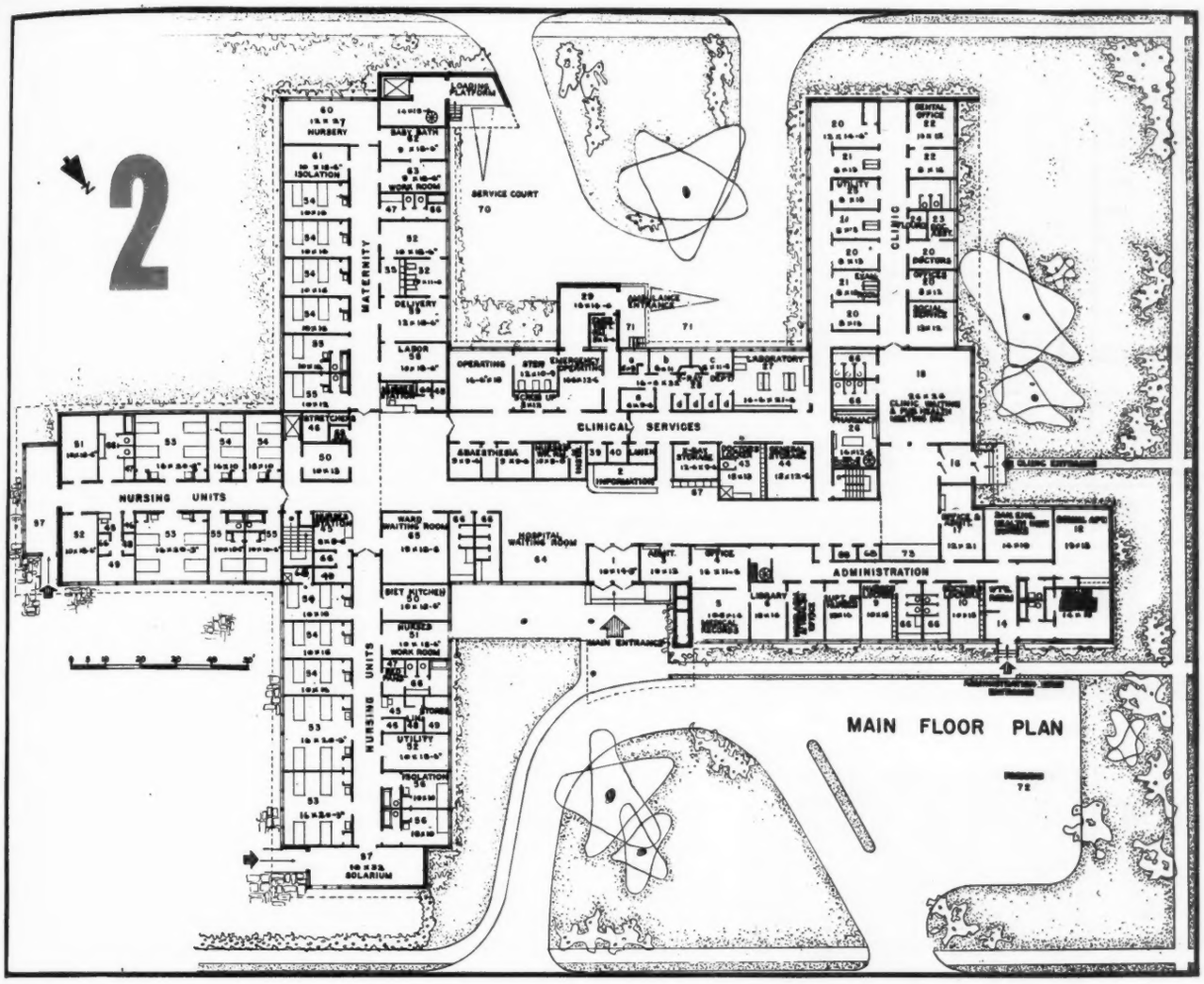
• THE DESIGNERS' STATEMENT

THE PLAN PRESENTED HEREWITH is for a 40 bed hospital capable of expansion to 60 beds, an out-patient department and facilities for the staff of the city health department.

Dansville, N. Y., according to the 1940 census, had a population in that year of 4976 persons. It is situated in the western portion of the state, about midway between Pennsylvania on the south and Lake Ontario on the north. It is 52 miles by first-class automobile highway due south of the city of Rochester. In this latter city, are located the University of Rochester and the University of Rochester School of Medicine and Dentistry, a grade A medical school affiliated with a large general hospital having all of the necessary special services.

Dansville is a nursery and farming center but, in addition, possesses factories for the production of heating equipment, textbooks, magazines, paper and shoes. Of the 1373 employed males, approximately 50 per cent are engaged as factory operatives and at various crafts.

Livingston County, in which Dansville is located, is



inhabited by 38,500 persons (1940 U. S. Census) of which 92 per cent are native-born whites. It is from a portion of this general county area, in addition to the city of Dansville, that the hospital will draw its patients.

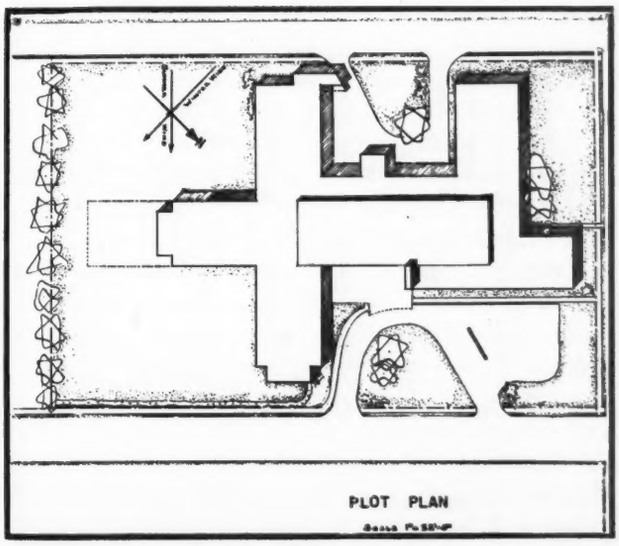
The prevailing winds in the city of Dansville during the months of January through May are from a westerly direction and from June through December they are from the southwest.

• THE JURY'S STATEMENT

A GOOD WORKABLE SCHEMATIC PLAN with the clinic area separated but nevertheless easily accessible to adjunct diagnostic facilities. Orientation is carefully considered with sun for patients and careful isolation of patients from noisy areas. The cubage of 462,000 is moderate.

The administrative spaces are well handled in relation to both hospital and clinic patients; the waiting rooms and corridors, however, are extravagantly large for a health center of this size.

The maternity section is segregated but the delivery rooms are located in too prominent a place, where all traffic to the maternity department has to go by them.



BASEMENT PLAN

2 (concluded)

The nurseries and the delivery suite should be exchanged.

Many rooms must depend upon a clerestory for outside light.

The x-ray department is cut up into too many rooms that are too small. There is no main radiographic area.

In general, the rooms and equipment are neither adequately nor clearly detailed.

In the basement there is sufficient space allotment for the engineer, for storage, laundry and food service. However, there is no outside light or ventilation shown for the laundry, power plant and records storeroom. The storage space is poorly allocated, the records storage being oversized if it is required at all in these days of microfilming and the general stores being too small.

The exterior is attractive.

3 $500

Fisher and Fisher of Denver is the uncle and nephew team that took first prize honors in the competition for small hospitals, plans of which were published last month.

Arthur A. Fisher, senior partner of a firm founded in 1892 and reorganized in 1906, was trained in the offices of leading New York City architects. As a member of the Atelier Barber, he completed the course at Beaux Arts Institute of Design and afterward spent a year of study in France, Italy, Spain.

Junior member Alan Fisher studied architecture at the University of Pennsylvania and M.I.T. and spent a summer session at the American School at Fontainebleau, followed by travel in France, Italy and Spain.

Both are members of the American Institute of Architecture.

• THE ARCHITECTS' STATEMENT

THE TOWN OF DOYLE is the seat of sparsely settled, mountainous Powers County. Doyle is situated in a rather narrow river valley at considerable altitude. The chief economic background for the town is the production and shipping of coal. Minor railroad shops are also located at Doyle.

Climatic conditions are not considered favorable, the adjacent topography being an aid to low-pressure atmospheric conditions and the high altitude conducive to short summer periods and long, cold winters.

Doyle has a population of some 5000 persons, most of whom are of foreign extraction and active in the mines and railroad shops. The remaining 15,000 inhabitants of Powers County are widely scattered and are for the greater part engaged in the grazing of sheep. Health and cultural conditions are far from ideal and the need for a medical educational program is acute. Venereal disease coefficient is high, potential tuberculous conditions need immediate attention and child care instruction, prenatal education and a general health program for Powers County are essential.

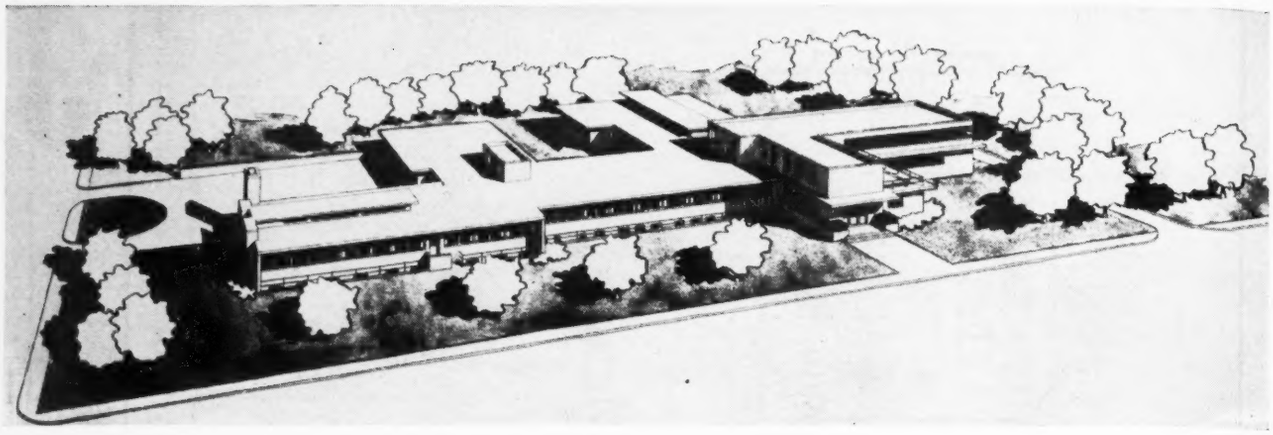
Prior to the construction of the combination health center-general hospital unit, medical aid for the county residents was available at a large state general hospital some 60 miles distant. The unit shown herewith is a satellite of the state institution and a close relationship of operation exists between the two.

The unit itself was designed to be operated as two separate entities—the center and the hospital. Arrangements exist, however, that make the services of one available to the services of the other. For this reason and for other economic reasons, the two units are included under one roof.

The Center: Survey showed the necessity for facilities for five examining doctors and two dentists. In this unit provisions have also been made for the distribution of drugs and medicine, demonstration and examining areas for the various branches and an assembly room for meet-

3

FIRST FLOOR PLAN



3 (continued)

ings, demonstrations and lectures relative to medical and hygienic education.

Owing to the low standard of living over a period of years in Powers County, the need for a sanitary engineer had become acute. Laboratory and office services have thus been provided along with accommodations for a health officer (full time) and a corps of county circulating nurses. Pathological laboratory services and radiographic-fluoroscopic equipment are available and convenient to the unit but located in the 40 bed hospital.

The Hospital: This unit is operated under the direction of a superintendent and is entirely separate in its operation from the health center described above. Only liaison and cooperation exist between the hospital superintendent and the health officers.

Facilities of this unit have been designed to meet the general hospital needs of the county. General services throughout, *i.e.* surgery, kitchen and laundry, have been designed to meet the needs of 20 additional beds planned for the future. The hospital is complete and "self-contained" as no existing services are available in the town of Doyle with the exception of bulk ice needs for nondomestic purposes.

No provision has been made for hospitalization of tuberculous or psychopathic cases, inasmuch as the state is well equipped for such nursing care at various institutions in other locations.

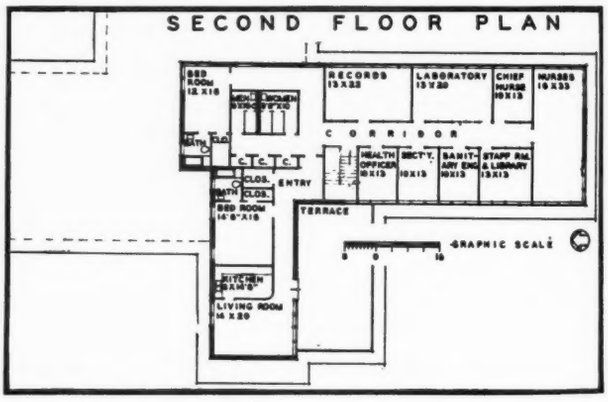
Owing to the rather unfavorable weather conditions and to the fact that prolonged recuperative periods are discouraged at this hospital, because of the low economic county condition, no luxurious services for ambulatory patients were countenanced.

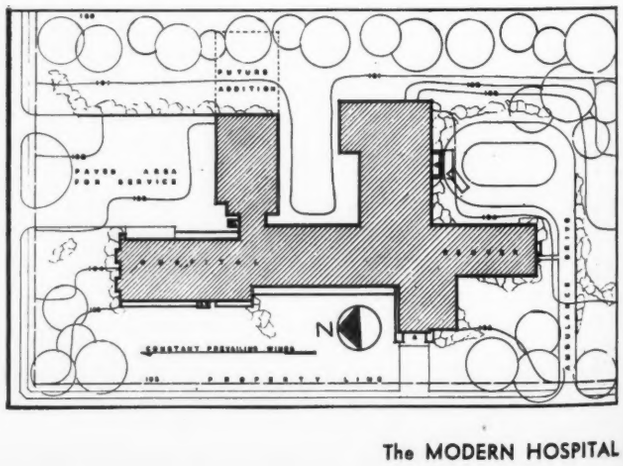
• THE JURY'S STATEMENT

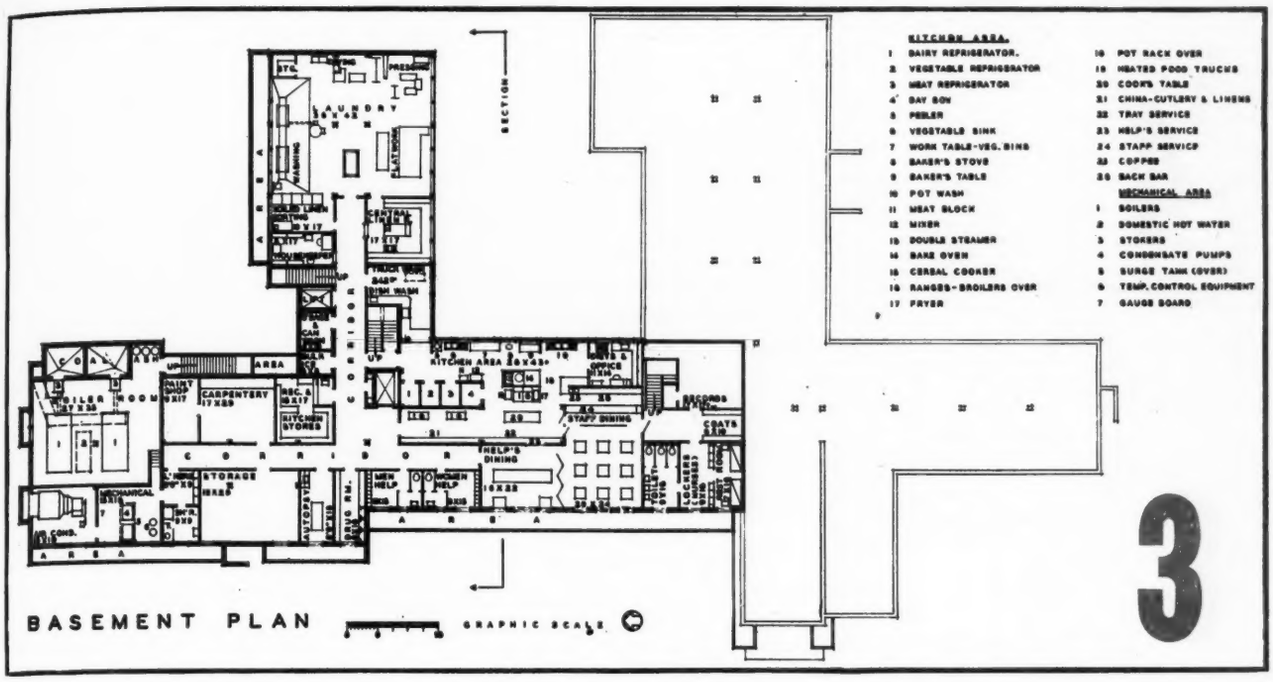
THIS IS A THOROUGHLY INTEGRATED PLAN. The health center is well situated in relation to the main entrance and is easily accessible to adjunct diagnostic facilities. The doctors' private offices are entirely inadequate and could not hold examining tables. The health center clinics are adequate and well done. It is questionable whether the doctors' private offices—presumably the only offices they will maintain in the community—should be placed in the clinic area.

The orientation of the building places all patients in the north part of the building and clinics and the health center in the south part, an arrangement that should be reversed. Also, half of the patients are in rooms on the noisy service court or on the main state highway side of the building.

The basement plan is excellent, thoroughly developed and spacious. While the dining area is in the base-







ment, this is partly above ground with ample areaways for light and ventilation.

The whole plan is carefully detailed and not fuzzy in any instance.

The suspect nursery should not be located within the delivery suite.

The exterior design, like the small hospital entry from the same team, is clean, functional and economical.

4

HONORABLE MENTION $100

For sixteen years, Laurence P. Johnston has been in government service and during much of this time he has been engaged in hospital building. His interest in this field emanates from his association with Thomas B. Kidner, hospital consultant, in the planning of the Children's Tuberculosis Sanatorium for the District of Columbia.

Employed by the U. S. Indian Service for the last seven years, Mr. Johnston was architect for the 335 bed general hospital for Indians at Tacoma, Wash., a plant that cost $1,250,000.

When he worked in the office of Arthur B. Heaton of Washington, D. C., Mr. Johnston designed the first park and shop store development featuring available parking space. An office building he did in private practice for Montgomery County and built at Silver Springs, Md., was awarded honorable mention in the public buildings classification by the Washington Board of Trade in 1936.

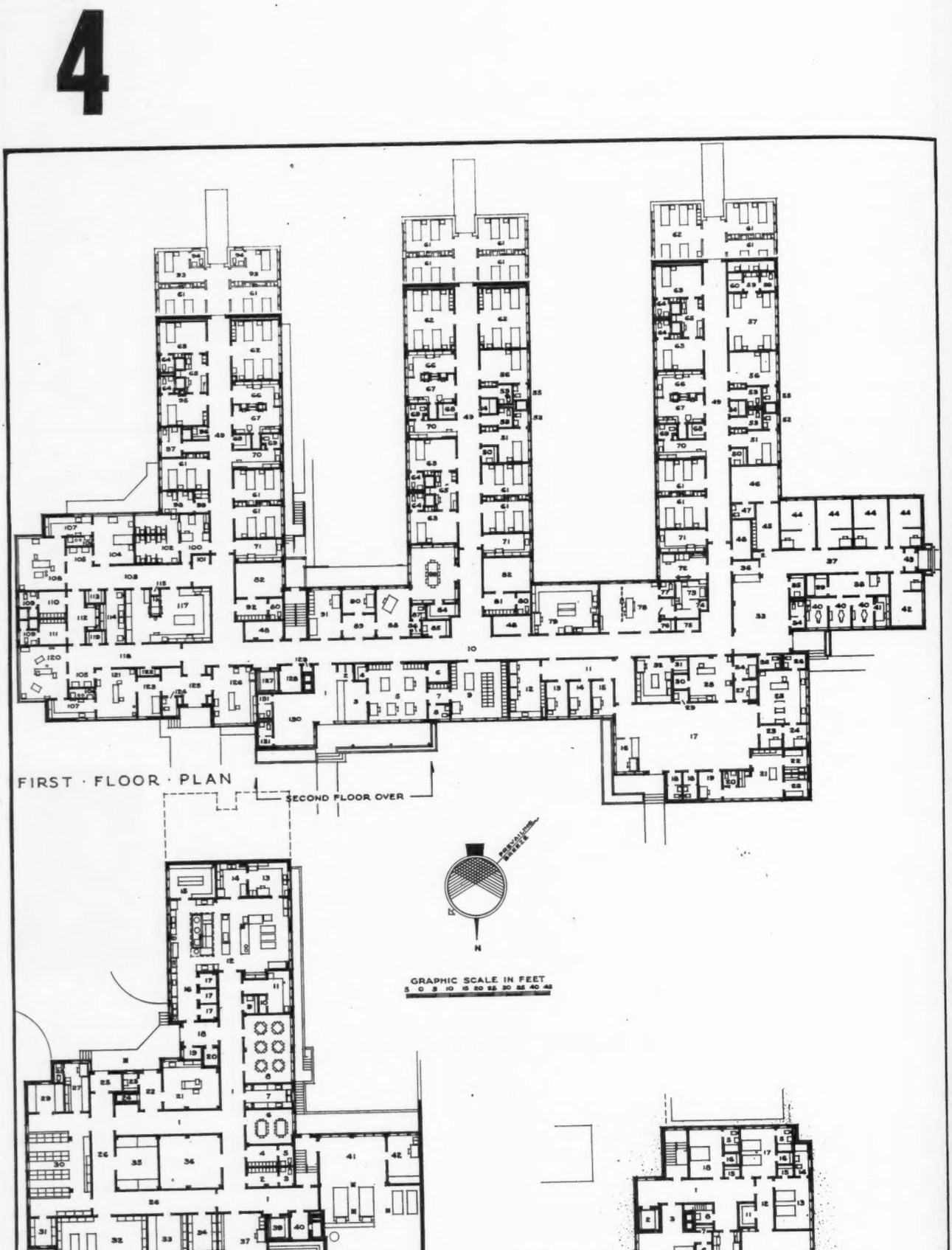
• THE ARCHITECT'S STATEMENT

AFTER A CAREFUL SURVEY, I found that only one of the 1046 towns in the United States with from 3000 to 5000 population is within 50 to 60 miles of a general hospital of 150 beds and is in need of better hospital facilities. That is Macon, Mo., with a population of 4206 in a county with a population of 21,396. It is 59 miles from Columbia by auto or railroad.

The area to be served extends 20 miles in each direction except south where service would be given for about 10 miles. This area contains 1014 square miles and about 25,000 people.

The nearest existing general hospitals are at Moberly (24 miles south) with three hospitals of 112 beds in all, at Brookfield (35 miles west) with one 14 bed hospital, at Kirksville (35 miles north) with two hospitals totaling 63 beds and at Hannibal (62 miles east) with two hospitals of 165 bed total. Two excellent hard-surfaced state highways intersect just north of Macon. The town is

4


FIRST · FLOOR · PLAN
SECOND FLOOR OVER
PAVILION
STREET
N
GRAPHIC SCALE IN FEET
BASEMENT · FLOOR · PLAN
SECOND · FLOOR · PLAN

LEGEND

FIRST FLOOR

1 Public Lobby
2 Telephone Booths
3 Information (and Switchboard)
4 Closet
5 Business Office
6 Vault
7 Passage
8 Employes' Toilet
9 Records Room
10 Main Corridor
11 Public Health Office Corridor
12 Public Health Nurses' Office
13 Health Inspector's Office
14 Sanitarian's Office
15 Social Service Room
16 Office and Admitting Area
17 Waiting and Assembly Room
18 Public Toilets
19 Consultation Room
20 Toilet
21 Maternal and Child Health Clinic; Demonstration Room
22 Examination Rooms
23 Nurses' Room
24 Consultation Room
25 Venereal Disease Clinic
26 Toilet
27 Nurses' Room
28 Clinic Room
29 Cleaning Gear
30 Darkroom
31 Drug Storage Closet
32 Pharmacy
33 Waiting Room
34 Toilet
35 Cleaning Gear
36 Receptionist's Office
37 Corridor
38 Waiting Room
39 Recovery Room
40 Operatory
41 Laboratory (and Darkroom)
42 Doctor's Office
43 Vestibule
44 Doctor's Office
45 Doctors' Locker Room
46 Doctors' Lounge
47 Toilet
48 Mechanical Service Room
49 Patients' Corridor
50 Cleaning Gear
51 Private Room
52 Toilet
53 Toilet
54 Bath
55 Toilet
56 Private Room
57 Four Bed Ward
58 Toilet
59 Wardrobe Space
60 Bath
61 Semiprivate Room
62 Four Bed Ward
63 Private Room
64 Toilet (With Shower)
65 Subutility Room Cleaning Gear
66 Utility Room (Sterile)
67 Utility Room (Soiled) Drying Closet
68 Linen Closet
69 Nurses' Toilet
70 Nurses' Station
71 Serving Pantry
72 Office and Viewing Room
73 Developing Room
74 Closet
75 Closet
76 Dressing Closet
77 Toilet
78 X-Ray Room
79 Laboratory
80 Toilet
81 Doctors' Locker Room
82 Lounge
83 Medical Library
84 Closet
85 Cleaning Gear
86 Closet
87 Toilet
88 Administrator's Office
89 Waiting Room
90 Secretary's Office
91 Office
92 Nurses' Locker Room
93 Private Room
94 Toilet
95 Private Room
96 Cleaning Gear
97 Toilet Room (With Shower)
98 Isolation Nursery (2 Bassinets)
99 Anteroom
100 Workroom
101 Viewing Alcove
102 Nursery (6 Bassinets)
103 Obstetrical Corridor
104 Labor Room
105 Scrubup Alcove
106 Equipment Space
107 Substerilizing Room
108 Delivery Room
109 Toilet (and Shower)
110 Nurses' Locker Room
111 Doctors' Locker Room
112 Instrument Alcove—Passage
113 Supply Closet
114 Utility Room (Clean-up)
115 Blanket Closet
116 Equipment Space
117 Sterilizing Room
118 Surgical Corridor
119 Anesthesia Storage
120 Operating Room
121 Emergency Operating Room
122 Cleaning Gear
123 Bath
124 Toilet
125 Emergency Entry
126 Treatment Room
127 Elevator
128 Storage Closet
129 Closet
130 Visitors' Waiting Room
131 Public Toilets

BASEMENT

1 Corridor
2 Men's (Help) Locker Room
3 Toilet
4 Women's (Help) Locker Room
5 Toilet
6 Help's Dining Room
7 Cafeteria
8 Staff and Nurses' Dining Room
9 Cleaning Gear
10 Closet
11 Dishwashing Room
12 Main Kitchen
13 Diet Kitchen
14 Formula Room
15 Day Storage Room
16 Preparation Area
17 Refrigerators
18 Service Entry
19 Can Washing Room
20 Garbage Refrigerator
21 Necropsy Room
22 Morgue and Necropsy Entry
23 Cleaning Gear—Storage
24 Mortuary Refrigerator
25 Storage Entry
26 Storage Corridor
27 Issuing-Receiving Office
28 Toilet
29 Bulk Storage
30 General Storage
31 Anesthesia Storage
32 Food Storage
33 Pharmaceutical Storage
34 Storeroom
35 Furniture Room
36 Unassigned Room
37 Housekeeper's Room
38 Linen Room
39 Elevator
40 Destructor Room
41 Boiler Room
42 Engineer's Office

SECOND FLOOR

1 Residentiary Corridor
2 Elevator
3 Foyer
4 Resident Physician's Room
5 Bathroom
6 Closet
7 Closet
8 Cleaning Gear
9 Kitchenette
10 Living Room
11 Closet
12 Entrance Hall
13 Bedroom
14 Bathroom
15 Closet
16 Closet
17 Bedroom (Guest)
18 Retiring Room (Obstetrician)

served by two railroads and two bus lines. The elevation is 875 feet and the country is gently rolling.

The soil is silty with brown and yellow loams; this is rich farm and cattle country. There are diversified hard and soft wood forests around the 3439 farms of the county. Average temperatures are 31° F. for midwinter and 79° F. for midsummer with extremes of—22° and 111° F. Average precipitation is 35.7 inches of rainfall and 23.2 inches of snowfall.

In addition to farming the area has clay and stone quarries and large strip coal mines. Fish and game are plentiful. Manufactures include packed meats, boots and shoes, flour, wood products, clothing, buttons and corncob pipes.

Having "discovered" Macon by extensive study of census data, I actually visited the town and selected a hospital site overlooking the fertile valley of the east fork of the Chariton River, near the 260 acre Macon Lake with its fine municipal swimming pool and other recreational facilities.

Public utilities include fine soft water, electrical energy at reasonable rates, both natural and manufactured gas, satisfactory sewers, good schools and up-to-date fire protection. There are ten churches, several civic clubs, a well-stocked library, a complete business center, a wide-awake newspaper, an excellent commercial laundry, a Duncan Hines-approved hotel and good restaurants and tourist courts. Some 300 business establishments do more than a $3,000,000 business annually.

Macon has a cooperative medical profession. The Samaritan Hospital provides 24 beds in an outwardly impressive structure which, however, lacks functional planning. It is not listed in the 1944 A.M.A. hospital register. There is also the Still-Hildreth Sanatorium (osteopathic) with 200 beds for nervous and mental disorders. It occupies an attractive 400 acre site just south of the corporate limits.

Macon is a typically American town. It is well planned and carefully zoned. It truthfully fulfills all of the mandatory conditions of this contest.

In planning both the hospital and the health center, I toyed with the idea of marking one wing for future construction. When I realized that this would mean one 26 bed wing for both surgical and medical patients and one 14 bed wing for maternity cases, I abandoned the idea in favor of a plan that permits expansion of surgical, medical or obstetric sections as may be needed, either individually or all at once.

If small efficiently arranged hospitals are to be built in smaller communities, I would suppose such flexibility in planning to be a distinct asset.

My plans embrace economy of construction since a one story structure can be built of any one of several materials. Likewise, the plans possess an ease of expansion that is unusual; the end rooms of each wing have a separate curtain wall to protect patients in these rooms while new construction is in process.

The ultimate in flexibility was sought by having either the small general hospital or the small community health center function identically as a hospital building irrespec-

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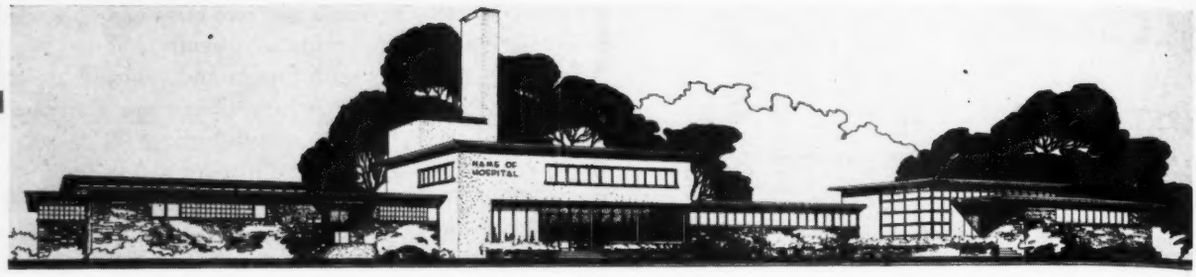


tive of its other facilities. The same kitchen and storage arrangements were employed in both.

Isolation rooms are served by a separate utility room that is equipped with a bedpan washer and sterilizer; utensil sterilizer; knee-action sink having a counter on either side with cabinets above and below; cleaning closet; soiled linen hamper; counter with hot plate with cabinet and drawers below and wall cabinet above, and built-in lockers for the nurses' garments. Food can be served to islolation patients in paper containers.

Such arrangements should prevent the possibility of cross-infection. Each room has a toilet and shower and can be used as a regular private room when not required for isolation.

The "island" in the general utility room contains the soiled linen hamper, bedpan washer and sterilizer, blanket and solution warmer, bedpan closet opening on both sides and a built-in pressure sterilizer with doors at each end. This plan was devised after careful study of bedpan and other technics. While the plan apparently has "clean" and "dirty" sides, all articles passing from the dirty to the clean side go through sterilization.

• THE JURY'S STATEMENT

THIS PLAN DESERVES SPECIAL COMMENDATION. It is an excellent plan with the health center and the doctors' private offices well integrated into the hospital proper, both being readily available to the hospital administrative area and to the adjunct diagnostic facilities, yet with a complete separation of the doctors' private offices from the public health department. There are private entrances to each.

The architect has given careful thought to proper orientation of patients' bedrooms, placing them to the south and (except four on the service court) all on the quiet areas.

The combined surgical and obstetric section is ably handled with a central sterilizing room serving both areas but with adequate segregation of these two services.

Equipment and furnishings of individual rooms are especially well detailed on the plans.

The receipt and control of stores in the basement is beautifully developed, with central storerooms directly off the receiving entrance. The morgue is well located.

The dietary department shows careful and competent planning. Of particular interest is the arrangement for dishwashing so that clean dishes come out of the dishwasher on the kitchen side and are not handled again by the person who is scraping dirty dishes in the dishwashing room. (The utility rooms have similar "clean" and "dirty" sides.)

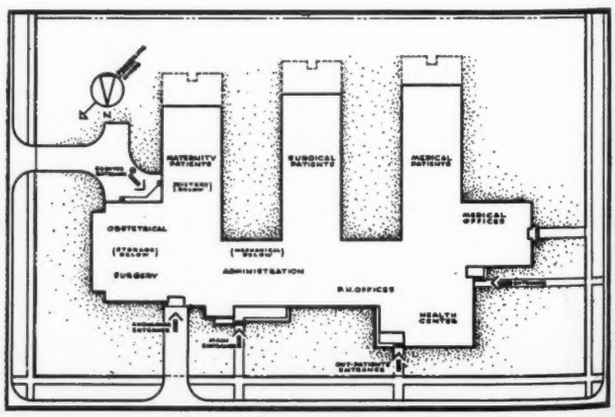
Living quarters for the superintendent and the salaried house officer are commodious and well planned and are located on the second floor for privacy. Special features not found in most plans are a bedroom for obstetricians and a guest bedroom.

The chief criticism of the jury was that in a hospital of this size three separate nursing units would be uneconomical, especially at night, since they are so placed as to require three nursing supervisors. This plan, however, would be ideal for a 75 bed hospital.

Also, this plan has the highest cubage (575,000 cubic feet) of any of those awarded prizes. Some of this cubage, of course, is due to the fact that every operation has been carefully thought out and space has been provided for it with all details considered.

The exterior design is well handled with extensive use of glass and a pleasing composition as a whole.

The jury regretted that this excellent plan could not be placed among the higher prize winners because of the widely separated nursing units. If the bed capacity specified in the competition had been larger, it would undoubtedly have been among the top prize winners.



5 **HONORABLE MENTION $100**

E. Todd Wheeler, University of Illinois 1929, is now associate architect for the university in charge of architectural work for the Chicago colleges of medicine, dentistry and pharmacy and the Research and Educational Hospitals. His work involves extensive planning for post-war expansion of the University of Illinois Chicago campus.

Since 1943 Mr. Wheeler has spent half of his time as director of planning for the Chicago Medical Center Commission, which involves developing a general plan for the 305 acre medical center district on Chicago's West Side.

Prior to his association with the university, Mr. Wheeler was associated with various Chicago firms and was a partner in Perkins, Wheeler and Will from 1936 to 1942. In 1933-34 he traveled from Sweden to Sicily on the Francis J. Plym Scholarship from the University of Illinois.

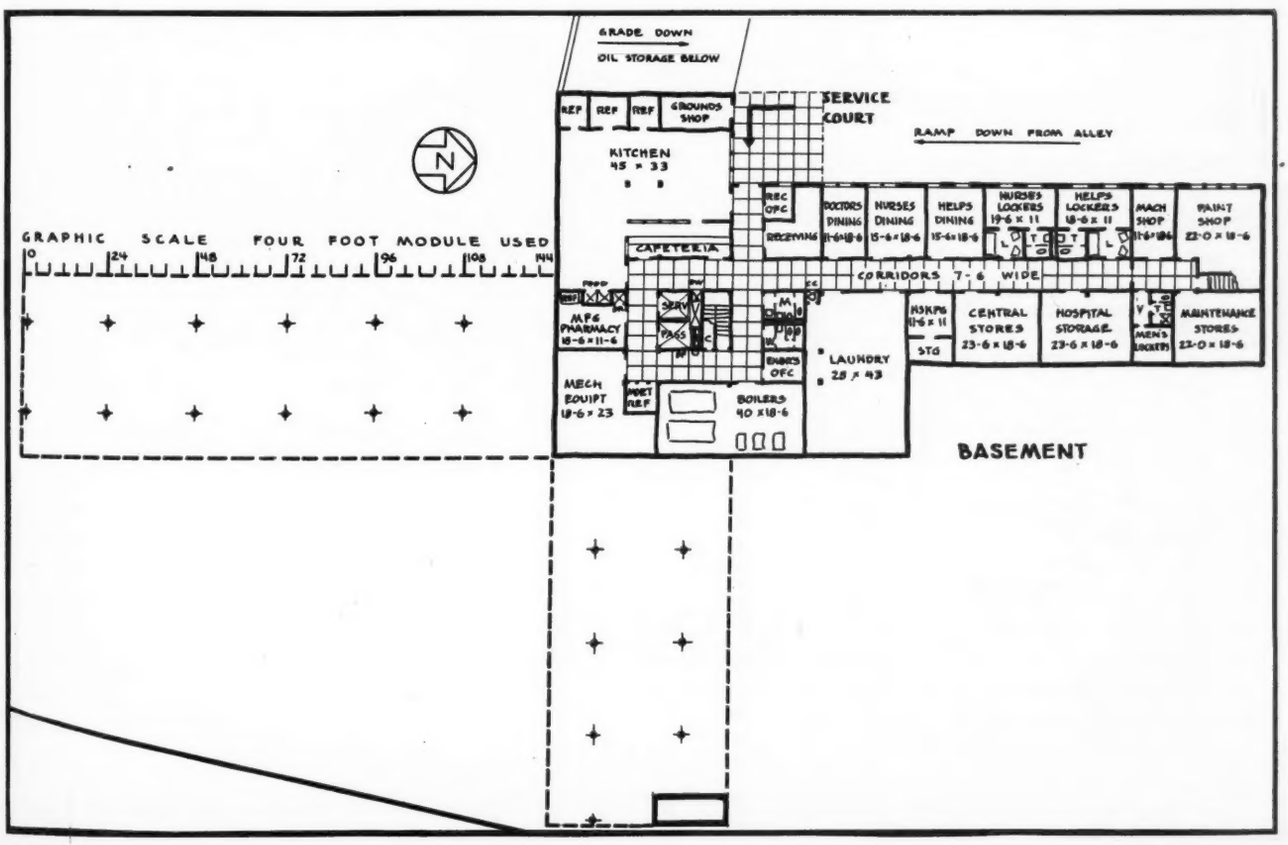
His avocation is water color sketching and oil painting.

• THE ARCHITECT'S STATEMENT

THE COMMUNITY in which this health center is to be built is in Wisconsin in the center of a prosperous dairy-farming area that includes other smaller towns.

The 5000 residents are largely engaged in business or in small industries which handle and process dairy and farm products. As a result, the town has an active well-kept appearance with homes ranging from a few quite large and pretentious ones down to a scattering of modest and inexpensive ones.

The per capita income is above average and there is a generally progressive attitude towards education and other civic enterprise.



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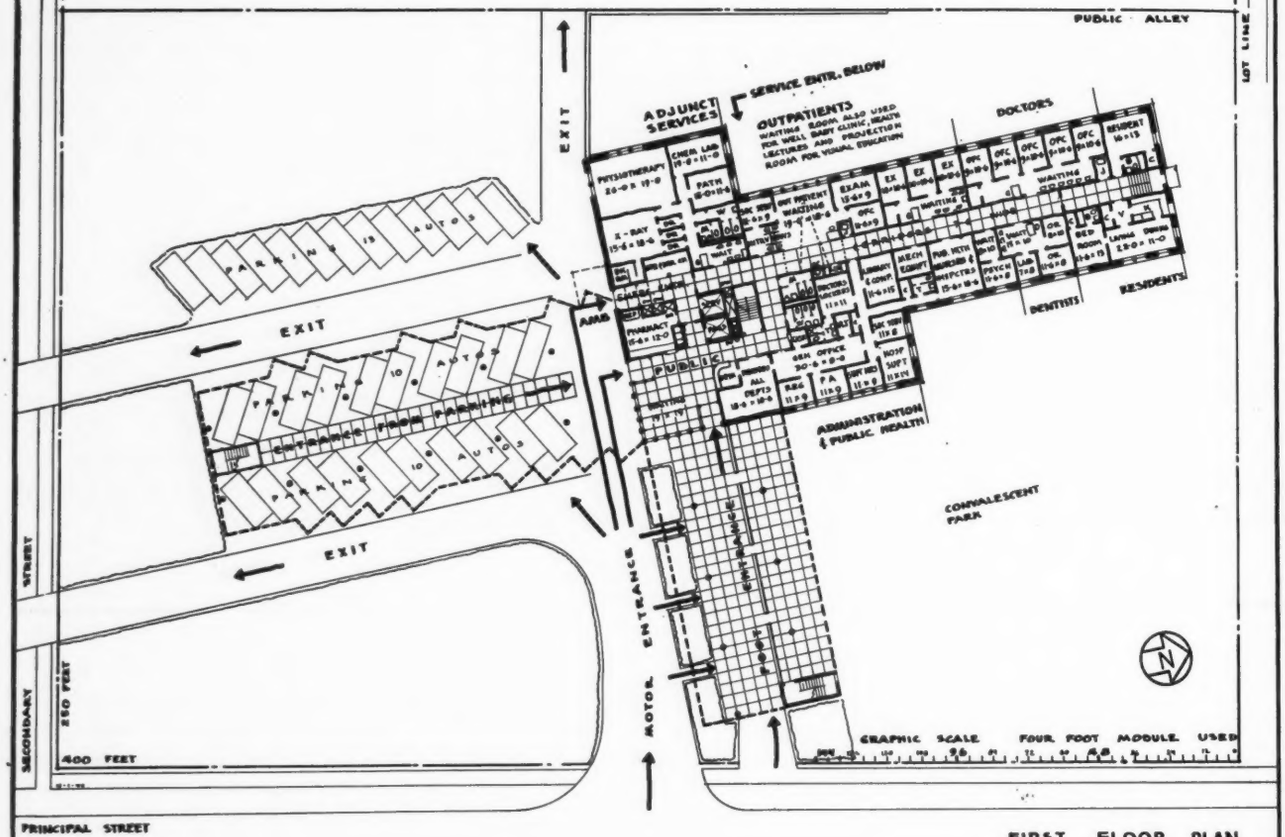
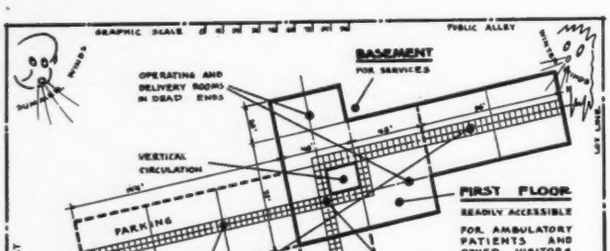
SOUTH EAST VIEW



FIRST FLOOR PLAN



PLOT PLAN AND DIAGRAM OF PLAN ORGANIZATION

CUBAGE

A	6 × 20 × 10-6	1680	F	16 × 28 × 10		9 980
B	98 × 96 × 19	69 512	G	98 × 198 × 19		99 760
C	98 × 96 × 23	105 984	H	12 × 5/8 × 13 × 19		5 460
D	72 × 96 × 35	241 920	J	8 × 16 × 10-6		1 344
E	24 × 98 × 35	80 320	K	1 × 19 × 10-6		200
				TOTAL		567 644

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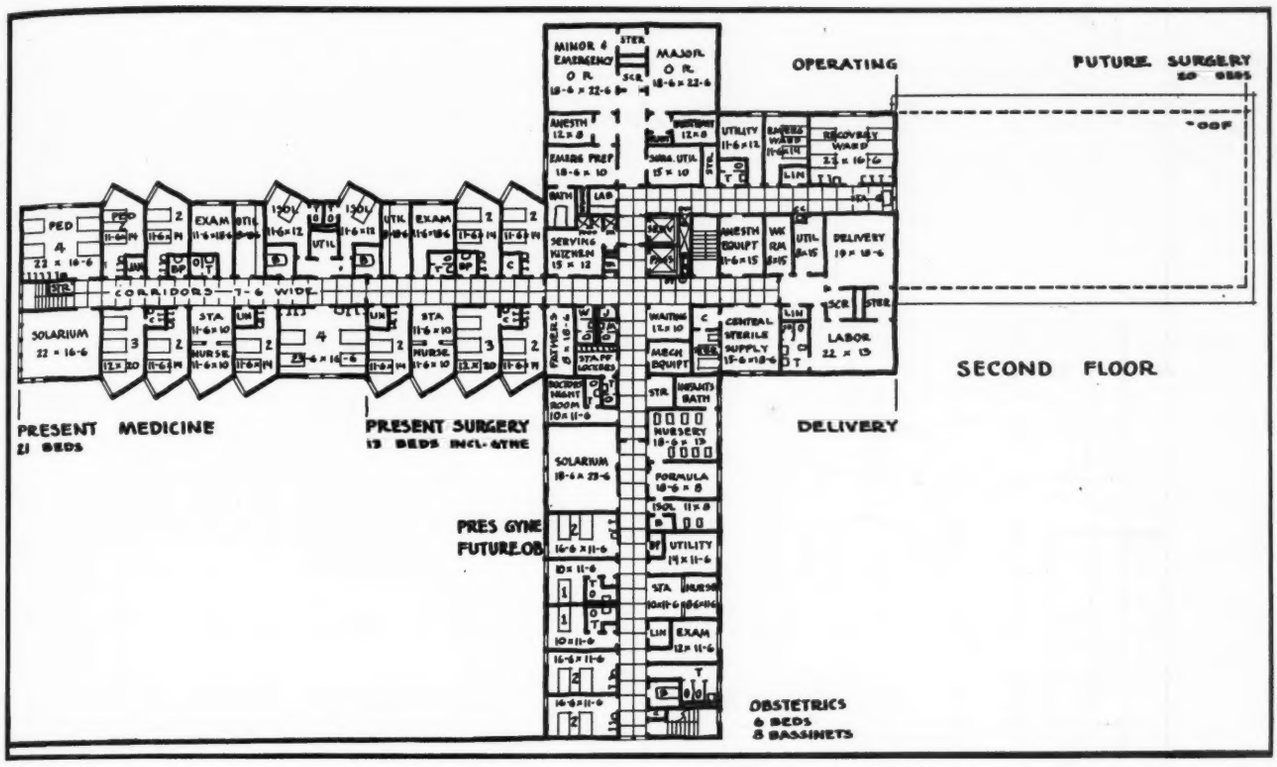


• THE JURY'S STATEMENT

AN UNUSUALLY INTERESTING AND DISTINCTIVE PLAN based upon a central core from which all departments radiate. The orientation of patients' bedrooms is carefully considered. However, serious objection might be raised to motor traffic directly under patients' bedrooms, particularly in the winter time in Wisconsin. Also, the jury had no sympathy with patients' rooms in which a wall blocks the patients' view of the outdoors. The saw-tooth arrangement of these rooms is also unnecessarily expensive. Others might like this no-glare feature.

The administrative and public health area is not well organized for operation and use of space. The general office would probably become a corridor to reach the administrator's office.

Adjunct diagnostic facilities are well located for both in-patients and out-patients. The doctors' private offices appear to be too small if they are to function as the only offices that these physicians maintain in the community. This was the intention of the competition.

The pharmacy is prominently located and will doubtless be very busy in this health center.

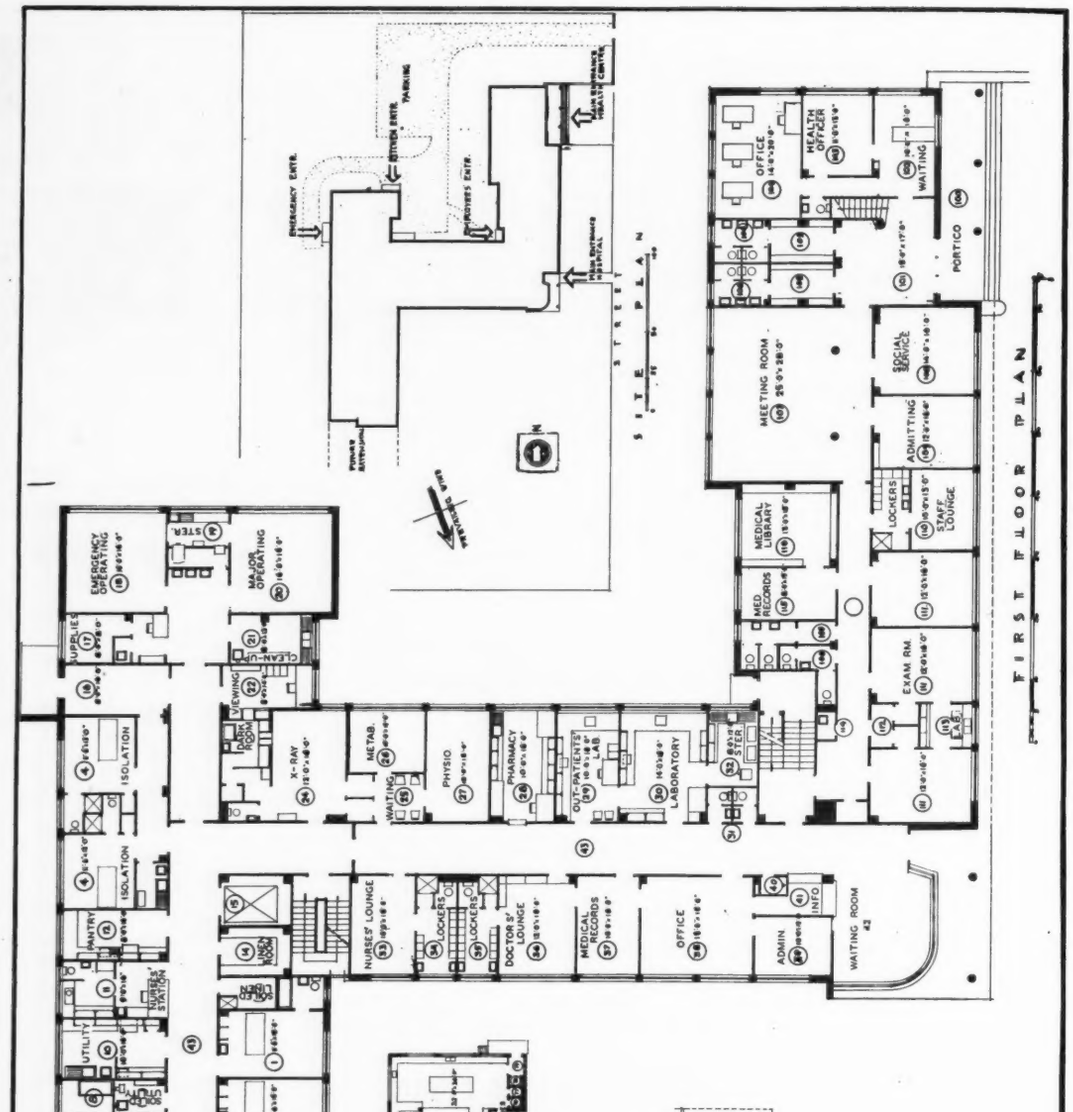
The second floor is well planned with separation of obstetrics and surgery and with maternity patients having a wing of their own. The combined medical and surgical patient area is well developed.

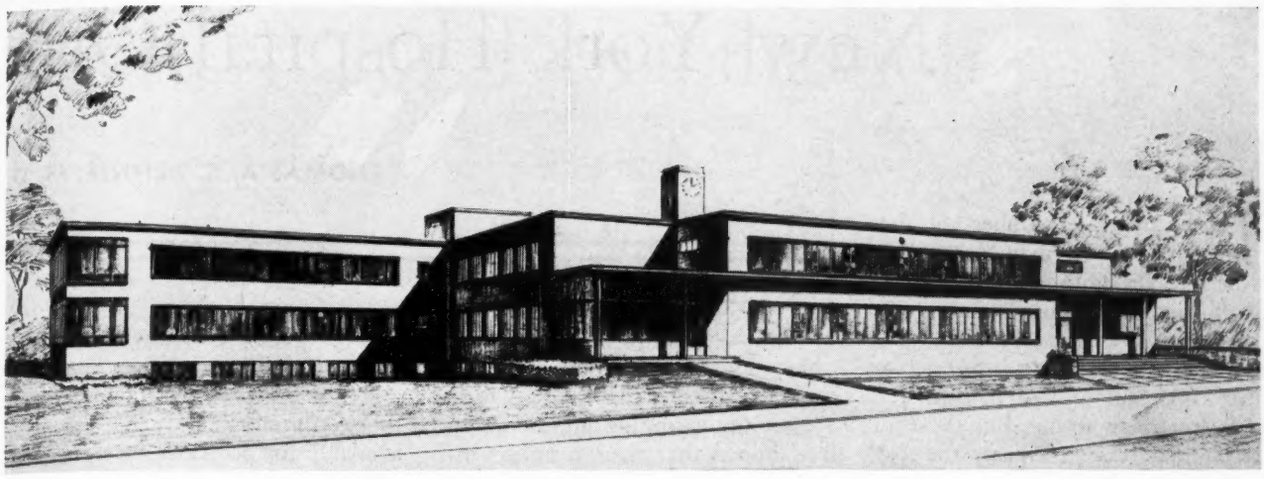
There are not sufficient single bedrooms. If there were, this hospital would not accommodate 40 beds.

Especially to be commended are the excellent locker and lounge facilities in the basement for nurses and women employes. No details are shown for the kitchen and laundry equipment.

The exterior design would probably appear strange to many people because of its novelty although there is sound basis for it in modern materials and methods of construction. Fenestration does not appear to be particularly happy. The relatively high cubage of 562,000 feet is undoubtedly due to the completeness of the plan which includes such features as a physical therapy department, office for a psychiatrist, a manufacturing pharmacy, a paint shop, a machine shop, a grounds shop, adequate storage space and restrooms, a formula room and generous utility room.

6


SITE PLAN
FIRST FLOOR PLAN
BASEMENT FLOOR PLAN
SECOND FLOOR PLAN
EMERGENCY ENTR.
KITCHEN ENTR.
PARKING
PHYSICIANS' ENTR.
MAIN ENTRANCE HOSPITAL
MAIN ENTRANCE HEALTH CENTER
FUTURE EXTENSION
PREVAILING WIND
N
OFFICE
HEALTH OFFICER
WAITING
PORTICO
MEETING ROOM 25'-0" x 28'-0"
SOCIAL SERVICE
ADMITTING
LOCKERS
STAFF LOUNGE
MEDICAL LIBRARY
MED. RECORDS
EXAM. RM.
LAB.
EMERGENCY OPERATING
STER.
MAJOR OPERATING
SUPPLIES
CLEAN-UP
SCRUBBING
DARK ROOM
X-RAY
METAB.
WAITING
PHYSIO.
PHARMACY
OUT-PATIENTS
LABORATORY
ISOLATION
ISOLATION
PANTRY
UTILITY
NURSES' LOUNGE
LOCKERS
LOCKERS
DOCTOR'S' LOUNGE
MEDICAL RECORDS
OFFICE
ADMIN.
INFO.
WAITING ROOM
DAY ROOM
KITCHEN
UNEXCAVATED
NURSERY



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HONORABLE MENTION $100

Canada's representative among the award-winning contestants is L. Forster, now a Canadian resident, who was born in Budapest. He received his architectural degree in Berlin in 1924 and was connected with the cooperative housing movement in Germany up to 1930 and also in Sweden. He planned and designed several large housing developments.

Mr. Forster went to Canada in 1939 and, until recently, was on the staff of Wartime Housing Ltd., a government agency for housing war workers.

In private practice he has been engaged principally in residential work and also in the design of interiors and furniture.

• THE JURY'S STATEMENT

THIS IS A GOOD, carefully thought out schematic plan with main entrance and health center entrance from the main street. The health department and the physicians' private offices are well located and nicely separated.

Bed patients are placed on the south portion of the building to receive full advantage of sun and quiet. Adjunct diagnostic facilities are readily accessible to the health department and to the doctors' private offices, as well as to the in-patients. The cubage of 417,000 feet is low and the plan is compact.

Surgical and obstetric departments are separated.

The basement is good except that personnel spaces (lockers and restrooms) are cramped.

It is highly questionable if in a hospital so small a central sterilizing room in the basement is feasible because of limited nursing personnel that needs to do double duty.

Maternity patients in the four bed ward (Room No. 3) are a long distance from the nursing station.

Equipment in the rooms has not been thoroughly detailed.

The exterior is simple and pleasing.

NOTE: Space limitations prevent the publication of all the competition plans that are deserving consideration by those who plan the building of a hospital or health center. The publishers plan to reproduce approximately forty of the best designs in a book. In addition to the plans themselves, which will be reproduced in larger size than has been possible in these pages, there will be a substantial amount of material by competent authorities on the subject of community hospital planning. The exact material has not yet been determined, nor has the final physical form of the book. Hence it is now impossible to state a price at which the book will be sold. However, the final volume will be a definitive work on planning small hospitals and health centers.

New York Hospital Offers A

THOMAS A. C. RENNIE, M. D.

THE growing numbers of men returning to civilian life from the armed forces with neuropsychiatric disabilities have focused attention on the urgent need for treatment facilities for them. The armed forces have little time and limited personnel to offer treatment to any but the combat fatigue cases. Hence, the psychiatric casualties, like the tuberculous, are being discharged. Already between 400,000 and 600,000 have been released.

The Veterans Administration is prepared to provide hospitalization for those in need of it, but well over 70 per cent of the psychiatric discharges do not need hospitalization. They need ambulatory care in their own communities with a view to reestablishing them quickly at work and in community life. Psychiatric facilities have always been meager. It has been estimated that to meet the mental health needs of America 10,000 new psychiatrists and a similar number of psychiatric social workers must be trained and a minimum of 1100 new clinics must be developed.

V.A. Facilities Not Organized

The Veterans Administration which is responsible for all service-connected disabilities has not as yet organized facilities to provide ambulatory care. Indeed most veterans' hospitals are so remote from community life that veterans cannot turn to them for the ambulatory treatment they need. The Veterans Administration proposes to purchase such service in established and recognized civilian out-patient clinics.

Similarly, state vocational rehabilitation bureaus that operate with federal funds and are now required to include psychiatric disabilities among the conditions eligible for such medical care as will render the individual capable of self-support have no organized clinics for such service. Thus it is that the burden will inevitably fall back upon the communities to which these disabled veterans return.

In a survey made recently of all psychiatric facilities available in this country, only 137 clinics have certified their willingness to make special provision for veterans' care.* Fortunately, special rehabilitation clinics are rapidly springing into being and it is hoped that their numbers will speedily increase. Most of these special clinics function on a voluntary basis, the staff members contributing their time. No charge is made for the service to the veteran. Through the two agencies previously mentioned, such clinics can derive a legitimate amount of income and contracts can be made now with the Veterans Administration.

In order to explore the possibilities in rehabilitation work and to study the processes involved, the New York Hospital established a rehabilitation service in August 1943. Our experiences have proved the feasibility and value of such a service and a number of other clinics have planned their organization and operation around the experience of this clinic.

The New York Hospital Rehabilitation Clinic operates one night a week and 12 volunteer psychiatrists, six psychiatric social workers, three psychologists, an internist, an electroencephalographer, three occupational therapists and a United States Employment Service placement officer contribute their time. The only paid staff members are a full-time psychiatric social worker and the clinic secretary. The clinic began with the usual and basic team of psychiatrists, psychiatric social worker and psychologist.

Social Worker Starts the Program

The social worker receives the patient and obtains an initial psychiatric history which enables the psychiatrist to go immediately into the treatment situation. She also deals with the family since, frequently, the man cannot be treated without attention to relatives and their attitudes, and she is in the position to know the community and the resources available for accessory services, such as the obtaining of recreation, social outlets and family case work. The psychologist contributes his experience in intelligence and aptitude testing, Rorschach and personality evaluation.

The psychiatrist is the central figure in the therapeutic situation. In our clinic the psychiatrist carries practically all treatment responsibilities. In other clinics there are three or four social workers to one psychiatrist and a psychologist is used only occasionally. In these clinics the social worker not only takes the history but does much of the psychiatric interviewing under supervision and with frequent conferences with the psychiatrist.

It is recognized that there are many areas where there will be few, if any, psychiatrists available. In such areas the work may have to be done largely by psychiatric social workers or by trained psychologists and the psychiatrist can be more profitably used for teaching and training purposes or for consultation on individual cases. The work of any such team requires speed, thoroughness and smooth teamwork.

Early in our own experience we discovered so many somatic problems arising intercurrently or blocking the road to psychotherapy that it was felt essential to add an internist to our own staff. The resources of internal medicine must be available for such a clinic but these can often be obtained from the hospital in which the clinic may be housed.

Since the finding of employment is so instrinsically a part of rehabilitation, a vocational counselor from the U.S.E.S. was added to interview the man at the clinic when the psychiatrist considered him ready for work. The use of the occupational therapist is purely optional but in our

*Directory of Psychiatric Clinics and Related Facilities in the U. S. 1944. Compiled jointly by Rehabilitation Division and Community Clinics Division. Obtainable from the National Committee for Mental Hygiene, 1790 Broadway, New York City 19. Price 25c per copy.

A Pattern for Rehabilitation

Associate Professor of Psychiatry, Cornell University Medical College
and Director, New York Hospital Rehabilitation Clinic, New York City

experience has been valuable in keeping the man interested during the time he is waiting for the psychiatrist, in opening up avenues of outside interests and hobbies in the arts and crafts and, occasionally, in obtaining valuable information as to his particular handicaps or emotional needs.

Leadership Is First Essential

The first requisite for the establishment of such a clinic is leadership: one or more persons or an agency or institution staff that have genuine convictions as to the need for and the practicability of a rehabilitation service. It is advisable to arrange for an advisory committee representing the major agencies in the community. This ensures representation from all the areas of importance for the task of rehabilitation and is the best way to inculcate the community with the aims, the works and the results of such a service. Such an advisory committee can open channels and make contacts for clinic patients.

The committee should include representatives of the major religious groups and their welfare interest, neighborhood houses, recreational groups, family and group work agencies, educators and vocational counselors, private and public employment concerns, industry (both management and labor), centers of arts and music and bodies for community planning, such as welfare or civic councils.

The clinic should be conveniently located in the community with reference to transit and travel facilities. It should be associated with some hospital, agency, department or institution which is well accepted in the community and which is a place to which people are accustomed to look for help.

The organization must be kept exceedingly simple. It is imperative to set up proper referral sources. These are commonly veterans' service centers, local draft boards, state selective service boards, private physicians, U.S.E.S. and social agencies. A necessary amount of publicity within the community will result in a number of veterans seeking help spontaneously.

Great care is needed in preparing the man for referral to such a service since about 20 per cent of the cases referred never turn up. A man cannot be overly persuaded but if he recognizes his difficulty and desires help he should be given explicit directions as to how to get to the clinic. It is important that as soon as possible after the initial referral the man be seen by a social worker. Unless a careful follow-up plan is made, many patients drop out and are lost from sight. Many of them can be persuaded to continue therapy.

The New York Hospital Rehabilitation Clinic has now had more than 500 men referred to it. The demand for service is far greater than we can supply. New York City has well over 40,000 veterans already discharged with a neuropsychiatric diagnosis. However, as has been shown in a study by the New York City Committee on Mental Hygiene, not all of these individuals want or are ready to accept help. In its survey it was shown that 80 per cent of neuropsychiatric discharges were considered in need of help whereas only 25 per cent of them recognized the need and wanted help. In New York City there are facilities to take care of only 5 per cent of them.

The aim of such rehabilitation clinics should be carefully defined: they should not merely duplicate outpatient services for psychiatric treatment. The number of individuals needing help is so great that no rehabilitation service can offer indefinite or long-term psychotherapy. Fortunately, in the majority of these men this is not needed. With the veteran group we deal essentially with acute upheavals precipitated by Army experience and these individuals respond surprisingly quickly to proper therapy. Nonetheless, it has been shown that approximately 70 per cent of all these casualties occur in men who had some predisposition to psychiatric illness prior to induction.

The aim should be a rapid reorientation of the men to a level as good as or better than prevailed before entering the service. The largest number of these individuals, being able to return to work relatively soon, should receive treatment while in the work situation. Many of them are able to pay for psychiatric care. Those who can should preferably be referred to psychiatrists in private practice. Many of the disabilities are of a chronic nature and existed long before the Army service. These should better be referred to existing and established out-patient services.

Many Are Quickly Restored

Work in rehabilitation clinics is a particularly gratifying experience. Many of these conditions, including even acute psychotic reactions, respond much more quickly to therapy than do comparable illnesses in a civilian. In our own experience more than half the patients report themselves as well, symptom-free or much improved in a relatively brief period of therapy. The type of treatment to be employed will vary with the individual psychiatrist and his own orientation. Our experience has been that an occasional patient can be oriented toward recovery in a single consultation, with guidance as to planning. For another group, making up about one fourth of the cases, brief psychotherapy, aimed at the discussion of resentment, the ventilation of traumatic emotional experiences, together with active social service help in making social contacts and finding appropriate employment, brings about speedy improvement.

A third group, about one fifth in all, consisting of depressions and hysterical and hypochondriacal reactions, needs repeated therapeutic interviews. With the second and third groups, group therapy methods

can be adopted. In other cases, where the problem is deep-seated and was well established prior to induction, intensive and prolonged individual psychotherapy is necessary.

There is some legitimate reason for questioning whether special rehabilitation clinics are necessary. It is true that such services should be tied in with general community activities and already existing psychiatric services, that they might well be conducted by already established hospitals or clinics and that the veterans' problems should not be considered too much of an isolated problem apart from other civilian groups.

New Services Needed Now

Nonetheless, most out-patient services are in no position to take on this new emergency load and experience has shown that effective, brief and incisive methods of therapy can be developed and employed to meet this new group. Furthermore, the case load is so great that new services are urgently needed if the majority of these veterans are not to go untreated and thus develop chronic illnesses, the cost of which to our government following the last war was $30,000 per case. Sheer economy demands that such new services be set up now.

Such services are springing up. New York City has at present six such special clinics. Boston has four with others established in Salem and Worcester. Chicago has recently established two; San Francisco and Los Angeles operate busy and successful clinics. Others have recently been established in Milwaukee and St. Louis. The Duke University Clinic serves all of North Carolina and part of South Carolina by traveling clinics that meet one day a week in outlying districts. Wisconsin has organized a statewide service drawing upon the voluntary time of every psychiatrist in the state.

The emergency of mental health needs among discharged veterans today makes mandatory the development of rehabilitation services. Although federal and state funds are available, the initiative and the service must stem from civilian groups, preferably from our civilian hospitals, which represent the major source to which communities inevitably turn with their problems of physical and mental health.

School for Medical Secretaries

PHYLLIS E. DAVIS

Director, Medical Secretarial Department
Business Training College, Pittsburgh

THE medical secretarial course offered at Business Training College, Pittsburgh, is designed to prepare young women for responsible positions as secretarial medical assistants in hospitals, in clinics, in doctors' and dentists' offices, in medical divisions of large corporations, in state or city boards of health and in any position where a knowledge of, and skill in, medical procedures and technics would be of assistance.

The course is being presented after conferences with physicians, dentists, registered nurses, public health officials and executives in Pittsburgh hospitals. In every case, the plan was enthusiastically encouraged and the curriculum is based in large measure on the suggestions received from those interviewed.

In order to assist efficiently, the medical secretary must thoroughly understand the field, its problems and its specialized terminology. She must also be poised and possess complete mastery of secretarial skills at high speeds.

Since not everyone has the capacity for learning technical subject matter or the natural aptitude for developing high speeds in skilled subjects, such as shorthand and typewriting, B.T.C. gives a series of psychological and clerical aptitude tests to all applicants for the course. Registration is limited to high school or college graduates with good personal qualities and better-than-average scholastic records.

The following types of tests are given:

1. A learning capacity test.
2. An English background test, including vocabulary, grammar, spelling, literature, punctuation and reading comprehension.
3. A clerical aptitude test, indicating ability to develop high speeds in secretarial skills.
4. A vocational preference test, indicating the applicant's preference for various fields of work.
5. A personality test, indicating character traits.

The information revealed by these tests, an interview with Dorothy C. Finkelhor, dean of the college, and with the head of the medical department, the personal situation of the applicant, past education, plans and ambitions, all are factors in determining whether the applicant will be accepted. Norms have been established for all the tests; applicants, in order to be admissible for the medical course, must come up to these norms.

A questionnaire was sent to 539 physicians representing 45 states and the District of Columbia. It contained check lists for office duties, laboratory duties and special qualifications. Of those answering, 538 checked the list of office duties and 495 checked laboratory duties. About 60 per cent reported that they employ medical secretaries, which indicates that physicians prefer assistants who combine laboratory training and secretarial training and that this type of worker is more widely used than that of secretary only or laboratory assistant only.

Doctors Prefer Cheerfulness

Highest on the list of personal characteristics specified by physicians as essential to a medical secretary are: pleasant relationships with people; a pleasant and cheerful disposition, and neatness. In order to develop those personal qualities that physicians deem necessary in a well-trained secretary, the personal development course, which is a part of any B.T.C. curriculum, will be integrated with the medical course. Included in the personal development program are lessons in speech, diction, English, carriage and posture, make-up and grooming.

Through our method of determining in advance the fitness of applicants for the medical course, those who are selected are assured that they not only have the natural qualifications for the work but also have every possible chance of being successful in the field.

Medicine and social work join forces in the war on

Rheumatic Heart Disease

MARY E. CLEESATTEL
Former Assistant Director of Social Service
Children's Hospital, Buffalo, N. Y.

THE clear skin, shining eyes and pink cheeks of the cardiac patient have long deceived both the public and the medical profession. Yet, beneath this picture of health lurks one of society's most devastating enemies, a crippled heart. It is only recently that the victims of rheumatic heart disease have received the attention and publicity they have long deserved. With the ever-widening scope of state programs for the treatment of crippled children, the cardiac patient has gradually made his way to the public heart.

The conclusions of this paper evolved as a result of a study of 103 children with rheumatic heart disease under care over a four year period at the Children's Hospital of Buffalo. Fifty-two per cent of the children came from conditions of inadequate housing and 83 per cent were suffering from malnutrition. Fifty-seven per cent of the families were receiving public assistance. Yet, suitable adjustment of these patients enabled a large number of them to lead not only happy but also useful and economically successful lives.

The adjustment of environment to facilitate recovery and prevent recurrence of the disease is a fundamental function in the medical-social treatment of a rheumatic patient.

Medical Social Work Helps

The nature of rheumatic heart disease opens untold possibilities for the medical social worker both in helping the doctor in the immediate treatment of the patient and in planning and supervising the long program of after-care during his period of convalescence.

Rheumatic heart disease is not spectacular. Its onset is slow and insidious. It is a chronic illness, the first attacks of which are often unrecognized. The symptoms may be as slight as a sore throat, a general rundown condition, "growing pains," loss of appetite, nose bleeds or joint and muscle pains.

The first attack, however, carries with it a predisposition to recurrent attacks, each of which imposes added injury on the heart. As a rule each succeeding attack increases in severity. An acute attack is characterized by fever, redness and swelling of the joints, pain and sometimes heart failure. Structural damage occurs in the tissues of the heart. The valves become thickened and scarred, thus interfering with normal function.

To appreciate this patient who often becomes an exasperating problem to the doctor and all of those who are trying to help him, let us look at the patient himself and try to understand how he feels. This diagnosis of heart disease is both sudden and startling to him. Perhaps he innocently came to the hospital expecting a tonsil operation because he had been suffering from frequent sore throat.

He is examined in the nose and throat clinic and told he can't have his tonsils out because he has a heart condition and must first see a heart specialist. This was the last thing in the world the frightened mother and child had expected to hear. They rush home from the hospital. The child is put to bed to stay until his appointment in the cardiac clinic. The whole family has a good cry that evening. The next day all the neighbors hear about it.

By the time the patient reaches the heart clinic he is a resigned invalid. Actually, he may be suffering from only a very slight defect which in time will be completely compensated.

Another parent brings a child to the clinic for a routine checkup, hoping to get a tonic for the child who has no appetite and is losing weight. She experiences the same shock when told the child has mild rheumatic fever and may develop heart trouble if not properly treated.

Then there is the patient with a severe attack of rheumatic fever. He is really suffering pain and discomfort. After a brief examination, the doctor says to a worried mother: "Your child will have to stay in the hospital for awhile; it's his heart!" This is a sudden shock and she's undecided. In her mind she believes the child will eventually die. Should she leave him there or take him home to have him with her as long as possible? What will her husband say?

The mother's attitude naturally affects the child. He becomes fearful and wants to go home. If available, the social worker can be of real help at this moment by giving reassurance and interpretation of the illness. Sometimes at this point the social worker establishes a relationship with this overwrought mother and child which carries through the entire period of the patient's care.

Heart Compensates for Damage

Following the acute stage, a long period of convalescence is required. It is during this time that the heart manifests its miraculous ability to compensate for the damage caused by the illness. Provided that the treatment is carried out according to the physician's recommendation, the prognosis is excellent.

Here again, however, we must appreciate the feelings of patient and parent. The child has spent from three to six weeks in the hospital. It may be the first time he has ever been separated from his parents. He is no longer suffering any discomfort. For a long time he has been restricted in his activity. He has

been forced to rest, rest and rest some more. Now he is bubbling over with energy. He's anxious to see his brothers and sisters, his friends and his pet dog. He wonders what he's missed in school. Possibly he fears he won't be graduated unless he gets back to school.

The mother has noticed the child's physical improvement from week to week and expects he will soon be home. The neighbor children ask daily when he will be back at school. Suddenly parent and patient learn that a long period of care in a convalescent home is the next step in treatment. Why hadn't they been told all of this in the beginning? The truth is they would probably have found it equally, if not more, difficult to accept such a large dose of recommendations at one time.

Failure to follow through this prescribed program of after-care may result in permanent injury to the heart, may even produce a cripple unable ever to earn a living.

Many Come From Poor Homes

Environmental factors play an important rôle in the predisposition to rheumatic fever. A high percentage of patients comes from overcrowded homes with inadequate sleeping space, irregular and unbalanced meals, continuous noise and excitement. Many of the homes are without cellars, giving a chill dampness to the atmosphere. Improper clothing, poor hygiene, exposure to infections and the absence of fresh air and sunshine are also important not only in the occurrence of the disease but also in its recurrence.

One little colored girl in this study was living with her mother, two younger brothers, a grandmother and two aunts in a small, dark, poorly kept flat, located behind a live-poultry market. The patient was sleeping on a cot in a small, poorly ventilated bedroom, also occupied by the two aunts, one of whom was under the care of the chest clinic as an inactive tuberculosis patient. Afternoon rest which the patient required was impossible because of the continuous noise of the cackling chickens in the front market.

Problems of this sort can only be solved by a cooperative relationship with other agencies. In the course of the development of this case, the public welfare department was helpful in straightening out a complicated financial situation in the home and, finally, in separating the families into their individual households. After the birth of this widowed mother's third illegitimate child, the agency made arrangements for her to marry the father of these children, thus providing a more normal and emotionally stable family relationship.

It has been said that the primary treatment of rheumatic heart disease is rest. This means rest of body and rest of mind. The latter is difficult in a household upset by emotional turmoil. When the social worker finds that the problems of family relationships are impeding the patient's recovery, she calls upon one of the family agencies for assistance.

In one instance a mother was unable to concentrate her attention on the care of her rheumatic child because she was so absorbed in her own marital problems. Through a cooperative relationship with the Family Service Society this problem was crystallized and resulted in a separation of the parents. The mother then found work and was able to pay for the care of her child. She had resented asking for public assistance when her husband was able but unwilling to pay for this care.

The medical social worker concentrated her attention on the child and prepared her for her return to her new home and the changed family situation.

Once the active disease has subsided, the problem becomes one of prevention. Recurrent attacks occur most frequently in patients whose general physical resistance is low. In view of the fact that a high percentage of rheumatic patients are in the lower income groups, sources of supplementary help are essential. In Buffalo there are numerous private agencies that provide extra milk and eggs. Convalescent care in the country is available for children of all ages.

Child guidance service should also be available because by its very nature heart disease is a source of emotional disturbance. Both parent and patient are often upset by the mention in the clinic of such technical terms as murmurs and irregular beats. Solicitude and overprotection on the part of parents may be reflected in the child through antisocial attitudes or a sense of inadequacy.

School plays an important rôle in every child's life. To be completely deprived of the opportunity for education makes the patient constantly aware of his handicap. The board of education in Buffalo provides special schools for patients able to attend school under guarded routine and home teachers for complete bed patients. Within the hospital and convalescent home a school program is also provided for long-term patients to the extent that their physical condition warrants.

An important field in which this community falls short in its resources for the treatment of cardiac cases is that of occupational therapy. Within institutions, such as the hospital and the convalescent home, occupational therapy is provided, but the group of patients receiving this privilege is a small percentage of those under care in the clinic. All patients in time must return to their own homes.

Occupational Therapy Valuable

Occupational training in the home would serve two important functions. In the first place it would have a therapeutic effect on the patient in transferring his interest from himself and his illness to the production of something worth while. It would give him a sense of usefulness. In a few cases the Volunteer Service Bureau has provided volunteers to take occupational work into the homes.

A trained occupational therapist working in cooperation with the physician and under his direction would be of inestimable value in the care of countless numbers of such handicapped individuals.

Second, occupational therapy might also provide a training for patients in occupations that could in future years prevent them from becoming completely dependent upon public funds for support.

Rheumatic heart disease is more than a medical problem because it is vitally affected by environmental influences. Recovery has the best chance of realization when the physician and social worker function together as a team with a mutual understanding not only of the patient's physical problems but of his whole social setting. Such understanding is still fettered unless the social worker has the knowledge and ability to bring into play all of the community's organized services to aid in the battle toward health.

ANNOUNCING THE MODERN HOSPITAL'S

COMPETITION

FOR AN ESSAY ON THE SUBJECT:

"A Plan for Improving Hospital Treatment of Psychiatric Patients"

FIRST PRIZE $500 ❧ SECOND PRIZE $350 ❧ THIRD PRIZE $150

THE SORRIEST SPECTACLE IN HOSPITAL SERVICE TODAY is the treatment accorded the psychiatric patient. Herded in a large isolated state hospital or in an unstandardized proprietary or voluntary institution, the patient often gets little more than custodial care. His medical care may or may not be scientific and efficient; his doctors, although often devoted, are usually underpaid and overworked. His nursing care is likely to be skimpy. His attendants may be poorly trained or indifferent and sometimes even brutal. Often nobody takes time to outline and carry on a program of intensive and constructive therapy which fully utilizes present knowledge. Some state and voluntary hospitals, of course, are exceptions; a few are very superior institutions indeed. ❧ GENERALLY SPEAKING, neither the profession nor the public has effectively demanded that standards for care of psychiatric patients be maintained at a high level, that adequate funds be provided to operate good psychiatric hospitals or units and that staffs be top grade and kept at the highest pitch of enthusiasm and ability. The public has a large responsibility but it needs aggressive and courageous professional leadership. ❧ EACH STATE AND COMMUNITY in the United States and each hospital providing care for these patients should have a plan for improving its hospital treatment so that as many as possible can be restored to their families and their home communities. For a community or state such a program involves: (1) the training of an adequate number of competent psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, occupational, recreational and other therapists, attendants and associated personnel; (2) the encouragement of research that will discover new technics for treating psychiatric patients and will refine and improve existing technics, and (3) the creation of strongly organized public and professional opinion that will demand high standards of treatment and will insist that personnel, physical facilities and funds be sufficient to achieve such standards. To make a contribution to such a program is the purpose of this competition.

The Judges:

Three outstanding authorities on hospital treatment of psychiatric patients will judge the essays. They will be drawn from: The United States Public Health Service, The American Psychiatric Association and The National Committee for Mental Hygiene.

The Conditions:

THE COMPETITION IS OPEN *to anyone except the judges and employes of The* MODERN HOSPITAL. *Hospital administrators, psychiatrists, psychologists, social workers, nurses, therapists, former patients, and any other interested persons are eligible to compete. Two or more persons may write a joint essay.*

LENGTH—The essays shall not exceed 5000 words in length. Shorter essays are preferable.

COPY—Essays shall be typed double space on one side of the sheet only. An original and two legible carbon copies must be submitted to permit the judges to read them simultaneously.

DATES—Essays shall be mailed to the Managing Editor, The Modern Hospital Publishing Company, 919 North Michigan Avenue, Chicago 11, Ill., in time to reach that address by October 1. Any essays received after October 1 shall be eligible for consideration only if they were mailed within the continental United States prior to midnight of September 25. Those mailing essays from abroad should allow sufficient additional time for transit. Registered mail is recommended. Winners will be announced on or before December 31 and notified by telegram. All other entrants will be notified by mail as soon as possible. The decision of the judges will be final. In case of a tie, duplicate prizes will be granted.

ANONYMITY—The essays submitted must have no mark or name which could serve as a means of identification of the author although his return address may appear on the outside envelope. With each entry must be enclosed a plain, opaque sealed envelope without any name on the outside but containing the name and address of the contestant. This envelope will be identified with the accompanying entry by the managing editor of The Modern Hospital and will be opened by him in the presence of witnesses after the jury has reported its decision.

SUBJECT MATTER—The contestant's plan for improving hospital treatment and care of psychiatric patients should not be narrow, covering only a single segment of the problem, but it can attack the entire subject from a special point of view, such as that of the administrator of a general (as well as a psychiatric) hospital, or that of the psychiatric social worker or nurse or attendant or public relations director or the patient himself or his relatives. What is not wanted is a scientific medical treatise, since that is outside the scope of this magazine. Contestants are urged to use imagination and to present new and promising ideas even though they may not have been actually tested as yet.

PUBLICATION—The Modern Hospital Publishing Company shall have exclusive publication rights to any essay submitted in the competition. In case the company decides not to publish certain of the essays submitted, it will on request release those essays to the contestants for such disposition as they may wish. Any essays published shall bear the name of the author.

HEADLINE NEWS

Release and Deferment of Medical and Dental Students Are Proposed

By EVA ADAMS CROSS

WASHINGTON, D. C.—The release and deferment of medical and premedical students from military service in order to aid in making possible the education and training of physicians and dentists to meet essential needs are the purpose of S. 637 introduced by Sen. Allen J. Ellender February 26.

Men to be released from active duty for such education and training must have completed more than one year of honorable service in the armed forces during the present war and they must have completed a substantial portion of the medical, dental, premedical or predental education and training necessary to qualify them as physicians and dentists. The release of any such person from active duty may be conditioned upon his acceptance by an accredited school.

The bill proposes an amendment of Section 5 of the Selective Training and Service Act to provide for the deferment from training and service in the armed forces of those men who are eligible for enrollment in the national medical and dental education program. The number of men enrolled at any one time in the premedical, medical, predental and dental training would be restricted and allocated by the President among the several states on the basis of population as determined by the 1940 census.

The President would prescribe the manner of selection of applicants within a state. Representatives of accredited schools that offer full-time courses of instruction in medicine and dentistry would be consulted in making such selections.

Ask Social Security Study

WASHINGTON, D. C.—A resolution will shortly be introduced asking for a comprehensive study of social security coverage, benefits and taxes, according to a spokesman of the House Ways and Means Committee March 22. An agreement was made in the last session of congress that such a survey would be attempted. John D. Dingell, co-author of the Murray-Wagner-Dingell Bill (H.R. 395) has made a motion asking the House for an appropriation of $50,000 for the study.

House Resolution Urges Investigation of Conditions in Veterans' Hospitals

WASHINGTON, D. C.—Gen. Frank T. Hines, administrator of Veterans Affairs, answering recent criticisms of veterans' hospitals, summoned the commanders of three veterans' organizations March 12 to go into the whole question of veterans' hospitalization.

The most direct congressional charge concerning conditions in veterans' hospitals was made by Representative Philbin's House Resolution of March 7 which asked that a committee be duly authorized to conduct an investigation into "alleged intolerable conditions, irregularities and hindrances affecting war veterans and members of the armed forces, in connection with hospitalization, medical and nursing services" and other matters. The committee would be comprised of five members of the Committee on World War Veterans' Legislation and six other members of the House, all to be designated by the Speaker.

The committee will investigate all hospital facilities, the resolution continues, the status, needs and progress of the hospital construction program, other facilities contemplated by present legislation, the personnel, the food, the discipline, restrictive regulations, care and treatment and all other matters affecting the rehabilitation and care of returned veterans.

A report would be submitted to Congress by this committee with recommendations for remedial legislation to eliminate undersirable conditions and unsatisfactory administrative practices, to provide abundant facilities and to ensure efficient, proper and generous care for patients in governmental institutions, for veterans and for service men and women.

A series of articles by Albert Deutsch, running in *P.M.* (New York City) has outlined many of the weaknesses of the veterans' hospitals. In the issue of March 12, for example, he stated that "nothing short of a thorough housecleaning and reorganization of the Veterans Administration, from top to bottom, could rid it of the peculiar corruption that has turned some of its beautiful hospitals into ghastly half-way houses to the cemetery for many veterans who could and should have been restored to health."

In the April issue of *Cosmopolitan* magazine, Albert Q. Maisel presents a documented case history of a tuberculous World War II veteran who pleaded vainly for the treatment he needed in a hospital in Dayton, Ohio, and then tried desperately to get transferred to a civilian hospital but died before arrangements could be made.

"Our disabled veterans are being betrayed by the incompetence, bureaucracy and callousness of the Veterans Administration," Mr. Maisel declared. "We have never stinted the Veterans Administration. We have given it over a quarter of a billion dollars to build a magnificent chain of nearly a hundred great hospitals. . . . Yet only one patient in six ever leaves these beautiful buildings labeled as 'cured.'"

"The corruption that affects the V.A. is not of the money kind," Mr. Deutsch reports. "It is, in a sense, even worse. It is the corruption spelled out in almost criminal complacency at the top in the face of steady deterioration, in a morbid defensiveness against constructive criticism, in monumental red tape, in mechanical procedures that ignore human values, in resistance to progress and modern methods, in an evasively inbred and aged bureaucracy."

General Hines recently asserted that veterans' hospitals are on a par with any in the country.

Nurse Draft Approved by Senate Committee; New Orders Pending

WASHINGTON, D. C.—The Senate military affairs committee on March 27 unanimously approved the house nurse draft bill as amended to draft married nurses under 45 without dependents. Male nurses serving as enlisted men in the Army are made eligible for A.N.C. commissions. Nurses who have taken religious vows are exempt.

Other amendments lift the Army-Navy ban on nurses serving in the same theater of war as their husbands and forbid discrimination because of race, color or creed. The clause drafting cadet nurses first was removed.

Other Washington news included the passage by the House on March 27 of the work or fight bill by a slim majority. This compromise measure will probably have rough going in the Senate.

W.P.B.'s long awaited preferential ratings to hospitals for obtaining textiles were reported to be almost ready to announce.

Burton-Hill Construction Bill Approved by Hospital, Medical Groups

By EVA ADAMS CROSS

WASHINGTON, D. C.—The Senate Committee on Education and Labor concluded March 14 a second series of hearings on S. 191, the bill proposing grants to the states for surveying their hospitals and public health centers and for planning construction of additional facilities. Earlier hearings had been held February 26 to 28. Testimony given before the full Senate committee indicated the active support of the American Hospital Association, the Catholic Hospital Association, the American Protestant Hospital Association, the American Medical Association and other organizations.

To date there has been no opposition to the bill.

"What Senate Bill 191 would provide is that the federal government would help the states fill out the missing pieces in the present hospital pattern and that the hospitals would continue to be under local government and voluntary management as they are now," said Surgeon General Thomas Parran. "A completely integrated hospital system is an objective to be accomplished by education, mutual agreement and such encouragement as the federal government may be able to offer."

The presence of hospitals and diagnostic facilities, possibly more than any other factor, determines the distribution and professional skill of physicians, the surgeon general pointed out. A hospital construction program, he continued, will provide scientific tools for the thousands of doctors who will be returning from military service.

"Hospital care is not a private commodity to be provided to some and withheld from others," Dr. Arthur C. Bachmeyer told the committee. He appeared on behalf of the Commission on Hospital Care. While he disclaimed any interest in influencing legislation, his testimony gave strong support to the pending bill. He strongly urged hospital surveys in every state.

A companion bill to S. 191 was introduced in the House March 6 by Congressman Neely. It has been referred to the Committee on Interstate and Foreign Commerce.

A.H.A. and A.C.H.A. Name Joint Committee on Education

A joint committee on education has been appointed by the A.C.H.A. and the A.H.A. to guide and promote university training for hospital administrators and to assist in such other work as educational methods, institutes and extension courses.

The A.C.H.A. is represented by Ada Belle McCleery and Drs. Claude W. Munger, Frank H. Bradley, Malcolm T. MacEachern, Arthur C. Bachmeyer and Robin C. Buerki.

The A.H.A. is represented by its newly appointed council on education consisting of James A. Hamilton, chairman, Edgar Hayhow, Sister Mary Patricia and Drs. E. L. Crosby, B. W. Black and Robert H. Bishop. The executive secretaries of the two sponsoring organizations are ex officio members with power to vote. Doctor Bishop is chairman of the commission.

The commission has formulated a large program and appealed to a foundation for support.

In addition to the education of hospital administrators, the new A.H.A. council will have some responsibility for educational work for department heads. At the present time institutes are being planned for personnel officers, public relations officers, accountants and purchasing agents.

Adopt New Plan of Appointing Interns

A new method of appointing interns has been agreed upon by the Association of Medical Colleges, the A.M.A., the A.H.A. and other hospital organizations, according to an announcement in March from Dr. F. H. Arestad of the A.M.A. Council on Medical Education and Hospitals.

Under the plan student records are not to be released to hospitals until the end of the junior academic year and hospitals are not to make intern appointments prior to then. Interns are requested not to file applications until they have completed the junior year. After students receive offers of appointment to hospitals they are to be given a ten day period for acceptance or rejection without any penalty.

A subcommittee has been set up to draft a uniform application blank for interns. Since most medical schools will not complete the current academic year until some time in June, it is anticipated that internship placement this year will not begin until July 1.

Surplus Property Board Prepares Regulations; Seek Hospital Buyers

WASHINGTON, D. C.—Regulations to effectuate the provision of the Surplus Property Act giving time priorities to tax-supported and nonprofit institutions for the purchase of surplus property are being prepared, the Surplus Property Board announced on March 2.

Sales are conducted by a simplified sealed bid method at the present time. Bids are publicly opened on an announced date. The board pointed out that restrictive state laws that prescribe competitive bids, posting of notices and public advertising make it impossible for some institutions to negotiate for purchases of surplus property.

The board has taken steps to call to the attention of state legislatures still in session possible legislation to put these priority buyers in a position to exercise their rights under the law.

Among items recently offered for sale are 3000 portable operating lamps, 99 hot air sterilizers, 1000 thermometer refills, a lot of 116,599 diagnostic and surgical instruments, supplies and treatment equipment and 925 surgical Steinman extension devices, as well as a variety of drugs.

A few of these items are "shelf-worn" and some surgical and dental instruments have been used. When used equipment is advertised for sale, prospective bidders are advised to inspect the merchandise.

Samples of smaller items offered are shown in regional office sample rooms, where Treasury Department commodity specialists, conversant with the medical and surgical field, are available for consultation with bidders.

Potential purchasers are advised of available merchandise through circulars or through the Treasury Department's monthly catalog, "Surplus Reporter," which is available on request from the nearest regional office.

Information on surplus property can be obtained from the nearest regional office, although purchases are made through whichever regional office has custody of the goods advertised.

These regional offices are located in Boston, New York, Washington, D. C., Cincinnati, Chicago, Atlanta, Fort Worth, Tex., Kansas City, Mo., Denver, San Francisco, Seattle, San Juan, P. R., and Honolulu, T. H.

Librarians Plan Institute

The institute for medical records librarians is definitely scheduled for the Knickerbocker Hotel, Chicago, for May 14 to 18.

GRO-5 Amended; W.F.A. to Extend Aid to Institutional Users

WASHINGTON, D. C.—Surplus inventories of hospitals and other institutional users have been recalled, according to an announcement of the Office of Price Administration March 6, when such institutional users have unused ration buying power and food stocks on hand. This action was effected by amendment 99 to GRO-5.

In the meantime, record-keeping requirements for hospitals have been simplified. Effective March 15, they will be given the option of one of three methods. They are:

1. A record showing the total number of persons served, persons served refreshments only and persons served meals for each day during the allotment period.

2. A record showing the total number of persons served, persons served refreshments only and persons served meals for each day during a representative week in each two month allotment period, and a record for the entire period of the total number of persons served.

3. A record showing the total of persons served, persons served meals and persons served refreshments only for a representative week in each period, a determination of the customer's "average check" for that week and a record showing total dollar revenue for the entire period.

The set-aside program for butter, which was to have been terminated February 28, will be continued indefinitely, according to an official of the War Food Administration on March 16. It will be continued from month to month with no guarantee that the set-aside program will not be halted. W.F.A. hopes that it will be able to continue such assistance to hospitals. Beginning with March approximately 700,000 pounds of butter per month will be made available to hospitals.

In chicken-scarce areas where hospitals are having difficulty getting the minimal of six tenths of a pound of chicken dressed weight per patient bed per week, W.F.A. will give such institutions priority assistance in obtaining their chicken supplies. It is contemplated that in most areas priorities will not be necessary, a W.F.A. official said. Poultry dealers will in all likelihood supply hospitals voluntarily. It was suggested that a satisfactory arrangement might well be worked out through informal conferences between hospital representatives, the poultry dealers and a W.F.A. district representative. Cooperation of the trade has been excellent on similar programs in the past, therefore, only after the voluntary plan has failed to work will W.F.A. give priority assistance.

Propose Establishment of National Neuropsychiatric Institute in U.S.P.H.S.

By EVA ADAMS CROSS

WASHINGTON, D. C.—A bill for the establishment of a $4,500,000 National Neuropsychiatric Institute in the U. S. Public Health Service was introduced in the House March 9 by Congressman Priest of Tennessee. The proposed legislation would also provide for more effective methods of prevention, diagnosis and treatment of neuropsychiatric disorders; would foster coordinating research relating to such disorders, and would assist in training personnel.

To enable the surgeon general to carry out the purposes of this act, $10,000,000, in addition to the cost of the institute, would be appropriated for the fiscal year ending June 30, 1946, and a sufficient sum would be allotted for each fiscal year thereafter.

These sums would be used, among other purposes, for grants-in-aid to the states and the District, to hospitals, universities and laboratories, public or private, under recommendation by the National Advisory Mental Health Council.

The surgeon general would be authorized to establish and maintain fellowships in the institute to procure the assistance of the most brilliant and promising research fellows from the United States and abroad.

The National Advisory Mental Health Council created by this act would consist of the surgeon general as chairman and six members to be appointed by him with the approval of the Federal Security Administrator. These appointed members would be selected from leading medical or scientific authorities who are outstanding in the study, diagnosis and treatment of neuropsychiatric disorders.

First Negro Nurse Sworn Into Navy

The first Negro nurse to be sworn into the Navy was commissioned in New York on March 8, according to the New York *Times*. She is Phyllis Mae Daley of New York City.

On March 1 the National Nursing Council for War Service and the National Association of Colored Graduate Nurses issued a joint appeal to the Army and Navy to accept more Negro nurses. While opposing any quota system, they pointed out that the 330 Negro nurses then in the Army Nurse Corps represented less than one tenth of the proportion of Negro soldiers in the Army. They estimated that at least 2000 of the 8000 Negro graduate nurses may be eligible for military service.

The Army had previously said, apparently erroneously, that the Negro nurses were now in the same proportion to total nurses that Negro soldiers are to total soldiers.

The use of more Negro nurses would add materially to military nursing resources in the present emergency, would give American women the opportunity without discrimination to care for the ill and wounded, would help to integrate professional services regardless of color and would attract young Negro women to nursing, the joint statement said.

Promotion for Navy Nurses

WASHINGTON, D. C.—Nurses of the U. S. Navy and the U. S. Naval Reserve will be promoted on the same basis as other officers of the Navy, it was reported by Capt. Sue S. Dauser, superintendent, on March 14.

"Bachelor of Nursing" Degree Proposed for Army, Navy Nurses

WASHINGTON, D. C.—To confer the degree of bachelor of nursing upon commissioned officers of the Army and Navy Nurse Corps was the purpose of a bill introduced in the House on March 13 by Representative Heffernan.

This degree would be conferred by the superintendent of the United States Military Academy and by the superintendent of the United States Naval Academy under certain rules and regulations prescribed by the Secretary of the Army and the Secretary of the Navy.

Inasmuch as such a degree would be a special recognition by Congress of the patriotism and self-sacrifice of the Army and Navy Nurse Corps, as well as their high degree of professional training and skill, the bill, if passed, would prohibit any college, university, school of nursing or other institution from conferring the "bachelor of nursing" degree.

O.W.I. Reports on Health Conditions Throughout Nation

WASHINGTON, D. C.—The physical and mental health of American civilians shows no indication of a serious decline despite war-time strain and shortages of physicians, nurses and hospital facilities, declared an O.W.I. report of March 1. The report was based on data furnished bv the U. S. Public Health Service, Procurement and Assignment Service, the Bureau of the Census and the War and Navy departments.

The darker side of the nation's health picture, according to O.W.I., showed the growing critical shortage of doctors and the admittedly bad distribution of medical care. There are about 100,000 physicians in the United States today. An additional 60,000 are serving with the armed forces. Of the 100,000 civilian physicians, some 20,000 are doing important research jobs in experimental laboratories, in disease prevention, in sanitation control and in war-vital administrative jobs. Some are too old to give more than part-time service and normal attrition by death and retirement removes approximately 3500 doctors every year with annual replacements totaling less than half this loss. The report dwelt on the increasing shortage of nurses.

The shortage of trained psychiatric personnel emphasizes a serious situation with respect to the mental health of the nation, the report continued. The number of psychiatrists available for civilian purposes in the United States has declined from a peak of 3500 before the war to a total of 2226 as of Jan. 1, 1945. Maldistribution affects the civilian supply of psychiatrists about the same as it does physicians.

Army Nurses Decorated

WASHINGTON, D. C.—For professional skill, determination and high sense of service exhibited, five members of the Army Nurse Corps have been decorated and one has been awarded a commendation, the War Department announced March 11. Maj. Louise M. Fitzgerald of Jacksonville, Fla., was awarded the Legion of Merit; Lt. (1st) Retha O. Rogers of Hubbard, Iowa, Lt. (1st) Josephine F. Sansone of Milwaukee and Lt. (2d) Bernice V. McDonald of Burkburnett, Tex., were awarded the Air Medal; Lt. (2d) Ruth C. Bimber of Beaver Falls, Pa., was awarded the Soldier's Medal, and Lt. (1st) Ledore G. Alsop of Fort Worth, Tex., was awarded a commendation.

Health Care Given Migrant Farm Workers

WASHINGTON, D. C.—Full medical, dental, nursing, hospital and public health care of more than 150,000 migrant farm laborers has been provided by the federal government through the formation of six nonprofit Agricultural Workers' Health Associations at a cost of about $18 to $25 per person per year, according to a report by Dr. Frederick C. Mott and M. I. Roemer which was published in Public Health Reports for March 2.

Because these laborers went from state to state as they were needed to meet harvest dates, no state or locality took any real responsibility for their health. So the federal government, with some state and local assistance, undertook a venereal program, the authors report.

Local hospitals are generally used to provide hospital care and, as far as possible, local physicians provide the medical service.

Although this group of people is more likely to have illnesses and defects than the general population, the costs reported are well below those generally given for comprehensive service. Some of the workers are Jamaican Negroes and Mexicans. The program is under the War Food Administration and is administered by officers detailed from the U.S.P.H.S.

Adoption Procedures Outlined

WASHINGTON, D. C.—Hospitals and their staff physicians will be interested in a report released on March 8 by the U. S. Children's Bureau warning against adoption proceedings while the true mother is under duress. "The finality of adoption imposes an obligation upon all concerned to protect the mother's rights so that she will not be under duress when making her decision," the bureau warns. The report is entitled "Essentials of Adoption Law and Procedures" and embodies recommendations and suggestions for a model law.

Urge Benefits for Seamen

WASHINGTON, D. C.—H.R. 2346, a sort of "G.I.-Bill" for merchant seamen, was introduced February 26 by Congressman Peterson of Florida. It provides aid for the readjustment in civilian life of those persons who rendered war service in the U. S. Merchant Marine during World War II. Among many other benefits proposed are those of hospitalization and medical treatment of war-service seamen in U.S.P.H.S. hospitals.

Penicillin Available to All Hospitals and Physicians

WASHINGTON, D. C.—Making penicillin available to all hospitals and physicians, producers and distributors started selling the drug through normal trade channels on March 15. It will be released in vials containing 100,000 units of sodium penicillin for human parenteral medication. W.P.B. has authorized the distribution of 1,280,000 vials from March 15 to March 31.

An additional quantity of approximately 1,500,000 vials will be made available for distribution in April. Similar quantities will be released each month.

Hospitals may now receive their needs from the various distributors of penicillin. It is no longer necessary for them to place orders through the Civilian Penicillin Distribution Unit in Chicago. W.P.B. says, however, that the Chicago unit will remain open for awhile to meet emergency needs. If a hospital is unable to get the drug from a distributor, it may order from the Chicago unit.

Cite Violation of W.P.B. Order

WASHINGTON, D. C.—The unauthorized conversion of a Detroit building into a general hospital at a cost exceeding $12,000 was reported by the War Production Board on March 13. Since Order L-41 imposes a $1000 limit on such construction, W.P.B. ordered the construction stopped. More than $12,000 had already been spent, however, by Mrs. B. J. Pollis in converting her premises into a hospital.

W.P.B. ordered the cessation of all construction, including completion, alteration or installation of any equipment or plumbing and electrical fixtures, until specific authorization is given in writing.

W.L.B. Sets Minimum Wage

WASHINGTON, D. C.—Fifty-five cents per hour has been set by W.L.B. as the new minimum wage rates below which income is insufficient to maintain a decent standard of living, according to an announcement of February 28. While hospitals are exempt from W.L.B. restrictions, this upward revision of the substandard wage minimum will doubtless affect their ability to employ workers.

On March 19 Senators Pepper, La Follette and Johnston introduced a bill which would direct W.L.B. to consider any wage rate below 65 cents an hour as substandard.

Progress Report on a Complex Problem:

Care for Crippled Children

LAWRENCE J. LINCK
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IN THE complex problem of providing care for crippled children there is, happily, complete agreement on one all-important point: that the crippled child should be afforded every facility and every skill that might alleviate his handicap, prevent its further progress or eliminate it entirely.

With agreement established on so basic a principle there can surely be no conflicts that cannot be resolved by good will and an intelligent consideration of the problem, coupled with a willingness to let any particular question be solved by whatever measures are found to be most fitting and proper.

Hospitals and State Cooperate

This approach is making constructive progress in Illinois, where the State Division of Services for Crippled Children, in conjunction with the Illinois Hospital Association and a number of its particularly concerned member hospitals, has developed a good plan of procedure and excellent working relationships that give promise of even more satisfactory results for the benefit of the many children in need throughout the state.

The Division of Services for Crippled Children operates as an independent unit of the University of Illinois. It has responsibility for carrying out a broadly conceived statewide program of medical, surgical, hospital and related services for crippled and physically handicapped children and for those children who suffer conditions which may result in physical handicaps. It has registered in its central file more than 30,000 children suffering from conditions that make them eligible for its services.

The division maintains eight district offices, one for each administrative nursing district throughout the state. From these offices field staff members maintain contact with patients and with local health, welfare, educational and other interested agencies and individuals.

The field personnel is responsible for the organization and conduct of some 140 out-patient diagnostic clinics held throughout the state each year. The standard personnel in the clinics includes an orthopedic surgeon, a pediatrician, an orthopedic and public health nursing consultant, a medical social worker, a speech and hearing consultant and, in most instances, a psychologist, a brace technician and various local volunteers.

In large communities the clinics are held in local hospitals which place their facilities at the disposal of the division, even though they may not qualify as approved hospitals for the care and treatment of orthopedic cases.

In the smaller communities where hospitals are nonexistent the clinics are usually held in public schools or churches.

In each of the clinics recommendations are made for the care and treatment of from 40 to 60 children who have come into the clinic center from the surrounding countryside, some of them from homes as much as 50 to 75 miles distant. Many of the recommendations for treatment call for periods of hospitalization which vary from as little as a few days to as much as several years.

Some of the children are of special interest to teaching institutions and a number of division patients are regularly admitted to the Illinois Surgical Institute for Children, the state hospital for crippled children maintained by the University of Illinois and supervised by the department of orthopedics of the medical college.

Quite aside from whatever value they may have for teaching, however, only a small portion of the division's patients can be accommodated in that institution, for the institute's total capacity is less than 100 beds. Most of the children under the division's care must accordingly be provided for elsewhere. The division has sought to make effective use of voluntary hospitals whenever they are adequately equipped and staffed to ensure the excellent care which the children need and which the division requires.

This plan has many advantages over a completely centralized program that requires all patients to be hospitalized in a single state-owned and state-administered institution. That it is more difficult to administer is readily admitted, but the advantages far outweigh the difficulties.

The use of good local hospitals serves to keep the children near their own homes with salutary effect upon their morale and that of their families. It serves, too, to keep active that spark of responsibility in the bosoms of their families which may easily smolder and blink out when the children are transported to distant centers and institutions—so unlike the kind of hospitals to which persons in the local community are accustomed to going when they become ill.

Develops Local Resources

Another important advantage in such a plan is that it tends to foster and develop local resources, professional skills and facilities in the finest American tradition of self-help. Local people are proud of their local institutions and like to be able to see them operate effectively to meet local needs.

This development of local resources is of special value in times of emergency, such as a severe outbreak

of poliomyelitis. If the local hospital is accustomed to handling polio cases, if the local medical men know the problem and include among their number specialists in orthopedics and pediatrics, and if there are especially trained nurses and physical therapists on hand, much of the hysteria and fear and poor care that usually result from a complete lack of facilities is avoided. Instead, we have a hospital which serves as a center for a greatly expanded specialty service and a foundation on which emergency facilities can be built.

That the operation of such a decentralized plan of hospitalization of crippled children serves to build up local community resources needs no special proof. Many an orthopedist has found it possible to establish himself in such a community and many more will be able to do so when they become available and are seeking openings at the end of the war. This is no less true of other specialists, all of whom enrich the communities to which they go.

What Are the Disadvantages?

This partial enumeration of the advantages of a plan that utilizes local facilities for patients under public care should be sufficient. What of its disadvantages? These may be particularly important to three, and perhaps I should say four, parties. First of all to the patients; second, to the voluntary hospitals; third, to the public agencies, and, finally, to the people as a whole.

Disadvantage to the patient would result from a lower standard of care that might exist in a small general hospital, or even a large one, for that matter, as contrasted with a great specialized medical institution created for the sole purpose of serving crippled children. This point need not be labored; it extends to physical plant, professional and other personnel, special facilities and consultant services.

The possible disadvantage to the voluntary hospitals lies in the danger that they might be imposed upon by a public agency which makes demands upon them for services without a concomitant willingness to bear a fair share of the costs. Public agencies have also been guilty of changing administrative policy, sometimes capriciously, to the disadvantage of voluntary hospitals which have modified their plants and staffs to accommodate the public agency program. Often, such changes in policy leave the voluntary hospital with substantial fixed charges and with little or no special source of income to meet them.

A possible disadvantage to the public agency is its inability to maintain proper standards of care when it lacks direct control and when a voluntary hospital may be contemptuous of the public agency's efforts to achieve such standards through suggestion or diplomacy or general advices that are hoped to be effective in regulation. It will be generally admitted that the average public agency is ill fitted to force action upon a well-established local institution which chooses to resist such action, except under unusual circumstances where the issue is clear cut.

Public agencies are also handicapped in their efforts to protect the funds placed at their disposal against inroads by well-entrenched local pressure and special interest groups. Thus, they are sometimes, to use a crude word, "gouged" by organizations whose charters would impute to them a different character.

The addition of the general public to this list of agents to which certain disadvantages might apply in a system of public agency purchase of voluntary hospital services is warranted by the nature of the disadvantages to the other parties. What hurts the children hurts the public, what hurts the voluntary hospital hurts the public and what hurts the public agency hurts the public.

These disadvantages, like the advantages previously set forth, are also merely illustrative. They are by no means a sufficient barrier to effective operation when there is a will to eliminate or circumvent them.

Public agencies that seek to establish in voluntary hospitals specialized services to meet the needs of their clientele should expect to pay the cost of those services and not seek "bargain rates," for there can be no bargains below true cost. They have a legitimate right to insist upon high standards as long as they are willing to pay the costs of them, and voluntary hospitals should recognize that right and strive to achieve such standards in fairness to themselves and to the public agencies.

The public agency should arrive at its policies through open deliberation and discussion, calling upon all representative agencies and individuals for advice and guidance. Limitations of law and of public policy should be recognized and appreciated by the voluntary agencies and they should assume a responsibility shoulder to shoulder with the public agency to have such limitations modified or amended whenever it may be in the public interest to do so. These should be grasped as opportunities to cement and strengthen good relations and not be made occasions for partisan conflict.

The voluntary agencies should endeavor to determine special costs accurately and to prorate or allocate them in a manner that will ensure the proper use of public funds, even though such a practice may result on occasion in self-denial.

The thorny problem of how to avoid placing a premium on inefficiency through rewarding it with higher cost payments should be a spur to intensive study by executives in public and voluntary agencies alike.

The Public Has a Responsibility

The responsibility of society-at-large for the successful operation of a plan so full of benefits for the people should be obvious. Public agencies must be supported with adequate appropriations to enable them to carry out their part of the contract. Good faith and a tradition of service on the part of the voluntary hospitals will complete the whole.

Long strides in the direction of more satisfactory care for crippled children have been made in Illinois, where substantial agreement has been reached by the voluntary hospitals and the Division of Services for Cripped Children. It remains for the representatives of the people in the General Assembly to provide the means of making the plan fully operative.

The Illinois Hospital Association, under the leadership of its president, Supt. Frank Hoover of the Decatur-Macon County Hospital, Decatur, Ill., is meeting the public agencies at least half way and is doing so in an attitude of good will and respect that is especially appreciated by our agency and, it should be added, in a manner that might well serve as an example to men of good will everywhere.

Saving Lives in the Jungle

Lt.(2d) MARJORIE TUBBS, A.N.C.

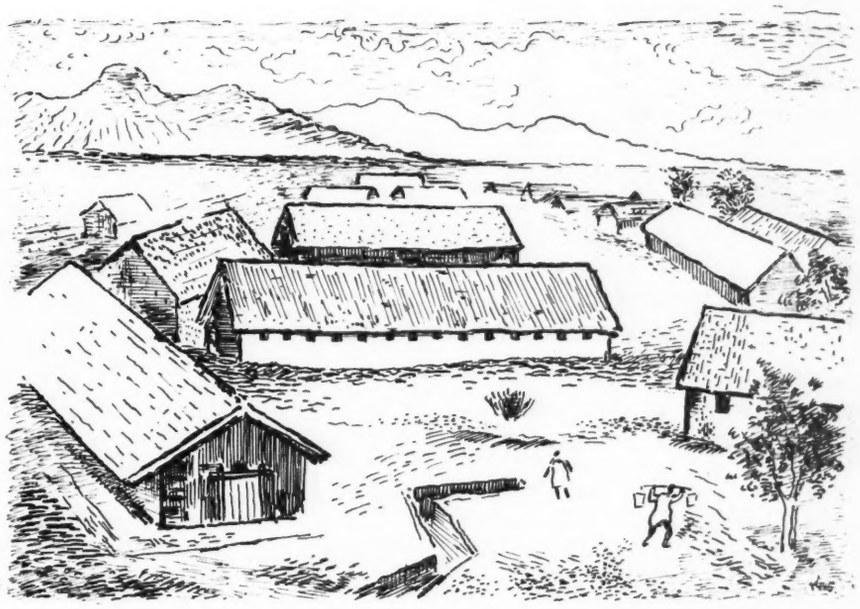
NURSES in the modern sanitary hospitals of the United States or even many who have been in foreign service would be inclined to marvel that lives can be saved in a jungle hospital of Upper India. Perhaps we would have felt the same way had we known at first how many complications affect the establishment of such a hospital.

Among our problems were a water supply that could never be used without sterilization, insects that practically blotted out the surgery lights even when the portable generator was working, weather that promptly rotted rubber tubing and rusted every exposed metal surface, extremely limited supplies and equipment that made improvisation necessary and patients who not only knew nothing of sanitation but had no qualms about changing beds in a weird Oriental game of "fruit basket."

Our unit, an evacuation hospital, was activated in Los Angeles in 1942 and sent to camp for training. Eventually our orders for overseas duty arrived and we were on our way. It would be difficult to explain our reactions when we were told our work was to establish a hospital in the jungles of India. India, the land of mystery and romance! It proved to be just that but it has nothing to do with this story.

On arriving in Bombay, we found that it was very hot, even unbearably hot, and after three days' rest we began a journey that took us across India, into Upper Assam and the jungles along the Ledo Road. We traveled by three different trains, riverboat and truck to reach our destination which was to be our hospital and home for more than a year.

The country where we were stationed was beautiful, with its large tea plantations extending to the edge of the jungle and the mountain ranges in the background, but on arriving we were too tired, dirty and wet to appreciate the beauty of it all. It was raining and it continued to rain for two weeks before we saw much of the sun. Fortunately, before we arrived, some of the jungle growth had been cleared away and a few bamboo huts or bashas, as they are called, had been made for us to live in until the rest of the hospital and quarters were built.



THE HOSPITAL WAS SET IN BEAUTIFUL TEA PLANTATION COUNTRY

There was much to be done and we were not free of many of the discomforts the jungle affords, such as moldy shoes and clothes, cold damp beds, mosquitoes, snakes and the almost constant rain and heat.

All buildings, including our quarters, were made of woven bamboo walls tied to a framework of bamboo poles and a roof of large leaves set on a lattice-work of bamboo. No nails are used in these structures as bamboo is extremely brittle and splits easily. One soon learns the art of using a reed tie in making shelves, furniture or huts of bamboo. At first, we had no floor, just bare ground which was always damp. Later, woven floors of bamboo were put down. These had to be replaced about every four months in the hospital area because of the wear.

A basha will last about a year with constant repairs to the roof, windows and doors. The rainfall was so heavy that many nights we would have to move our beds and those of the patients to keep from getting wet. Shelter halves were strung up over our beds in quarters to assure us of a drier bed to sleep in.

The wards were built in a quadrangle with a small central basha being used as a nurses' station for all four wards. This permitted using fewer nurses for a quadrangle. Each ward had a bed capacity of 25 Army cots and we had several larger wards that accommodated 50 cots. A heavy wire was strung down each side of the ward along the aisle and to this were tied the mosquito nets used on each cot.

Along the wall under the windows another wire was strung, which was used for a towel rack and hooks were made for drinking cups. Later, we fashioned bedstands which the natives built for us. Bedcard holders made of old x-ray film were tied to the wire holding the nets, thus enabling us to have the patient's name, diagnosis and admission date easily available for the medical officer.

At one end of each ward were a partition of bamboo and a shelf made of the same material, which served for a linen and supply room. Also at this end of the ward were a rough table and chairs for the officers and corpsmen. The medicines, dressings, charts and extra

CHOW LINE. AFTER EACH MEAL PATIENTS WASHED THEIR UTENSILS

supplies were all kept in the central station.

Five gallon gasoline cans, the type used as spares on Army motor vehicles, were used for the drinking water and each ward had one near the desk. The extra cans were kept in the central station because the patients would use the water for washing. Our patients, most of whom were Chinese, were not allowed to get the water from the containers as we were afraid of contamination.

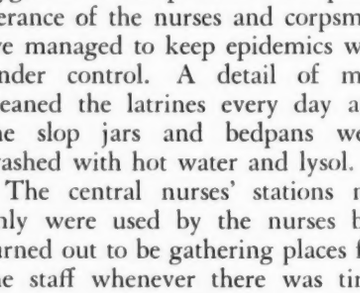
Water was boiled in large cans and then chlorinated and put in these containers for dispersal to the wards. It kept a crew of men working night and day to keep enough water boiled for our use and oftentimes we would have to drink it while it was still hot, which was not pleasant. The Chinese, however, like hot water and when they first came to the hospital they would not drink water unless we heated it. As most of the time we were much too busy to do this, we had to force them to drink the cooled, boiled water and have an interpreter explain over and over why this was necessary.

At the side or back entrance of each ward, we built washstands of old boxes or bamboo and here we had the ambulatory patients wash. Water was piped outside each quadrangle from a water tank which was kept filled by pumping the water from the stream near by. We had a few basins for each ward and the patients took turns in using them.

Latrines were built near each quadrangle and slop jars were placed at each end of a ward at night so the patients would not have to go outside in the dark. With so much dysentery our problem of sanitation was a constant source of worry for these people have no conception of hygiene. With patience and perseverance of the nurses and corpsmen we managed to keep epidemics well under control. A detail of men cleaned the latrines every day and the slop jars and bedpans were washed with hot water and lysol.

The central nurses' stations not only were used by the nurses but turned out to be gathering places for the staff whenever there was time out from work. Tables and chairs were made out of old packing boxes and the nurses managed to buy some cups and keep the cupboard supplied with Indian coffee. With a two-burner gasoline stove, a granite pitcher and chlorinated water, the nurses became quite good at making coffee even though we had to resort to the native brands.

GOOD PATIENTS, BUT CURIOUS



In this central station the nurses used their own ideas of decorating to make it a little gayer. Pin-ups and decorations would be taboo in a hospital at home but here they meant a lot to everyone. Calendars were made by ruling a blank piece of paper and marking the days in colored pencil. Bamboo was used for ash trays, pen and pencil stands, medicine trays and even applicator sticks when supplies ran low.

Patients brought into the receiving basha were stripped of all clothing and given a shower. A small basha back of the receiving unit had been fixed up as a shower room with tin cans punched full of holes for shower-heads. All clothing was tagged and placed in individual canvas bags and sterilized before being brought to the wards. It kept two men busy with one sterilizer running all day to do this work.

The patients were given clean cotton pajamas and sent to the wards with their personal belongings and mess equipment. Cotton blankets and unbleached muslin sheets were used for linen. When a patient was discharged we had him wash the sheets; blankets were sent to the sterilizer.

Our first surgery was a small basha partitioned off into three rooms, one for a dressing room, one for a workroom and the other for the surgery. Enough cement was found to make a floor throughout the basha. To prevent mud from being carried into the surgery, one took off his shoes outside and put on sneakers or an old pair of clean shoes before entering.

The surgery was lined with a fine, white mosquito netting bought at the bazaar and sewed by the nurses. This was done to prevent flies, mosquitoes and hundreds of other small flying insects from entering the room through the woven bamboo walls. A net door opened into the workroom. In spite of all this, there were many small insects that entered the room at night whenever it was necessary to run the lights. This made operating difficult and hazardous but we were fortunate in not losing a patient from postoperative infection.

Here too, the nurses decorated. Stars were made of blue material cut from some of our old dresses. The Southern Cross and the China-Burma-India emblem were all made out of material collected from the nurses. They were put on the ceiling so that when one entered the surgery there was more to see than just a white mosquito net.

All sorts of jars, cans and boxes were used for sterile supplies. We had one small gasoline-burner sterilizer which was in use most of the twenty-four hours until our supplies arrived many months later and we could boast of two larger sterilizers, although these were still heated by a gasoline stove. As supplies were slow in arriving, dressings were washed out and resterilized.

Later we boasted of our new surgery for we had two major rooms and two minor ones with a large workroom and cupboards for supplies. This building and the x-ray, laboratory and cast rooms were built of plywood and plastered. Screen windows and doors were also built and a cement floor was laid throughout the entire building. We felt very elegant in our new, yet crude, surgery.

One of the problems we had was rubber tubing. The climate and its inevitable mildew rotted the rubber. We had so few intravenous sets, which were in use most of the time, that sterilizing them became a nightmare because of the tubing. Instruments had to be kept oiled every day for nothing was free of rust.

We learned to improvise with many things. Our cast-cutting knives were made by one of the enlisted men. Basin stands, instrument stands and intravenous stands were made from scrap lumber. Large bolts of gauze were cut by the nurses and distributed to the wards where the patients were kept busy folding it for dressings. The Chinese liked to do this for us so it was no trouble at all to keep well ahead of our need.

With all the hardships and heartaches over equipment and supplies, we had our amusing incidents. Most of our patients were Chinese who had never seen an American nurse and had never known such comforts as our hospital afforded them. They were good patients but exceedingly curious and liked to wander from ward to ward to see what was going on. It was not unusual to look up during an operation and see the windows lined with curious Chinese faces.

Because it was difficult for us to distinguish one from the other and hard to keep them in bed, it was not unusual to find the wrong patient in the wrong ward and bed. They would just crawl in whenever they were tired of wandering around and then it was a scramble to find where they belonged.

We had no electricity for months. Kerosene lanterns were used at night except in surgery where there was a small generator for electricity. Later on, large mobile generators were installed and lights were wired to each central station over each desk in the ward and to our quarters. Electricity was available until 11 p.m. and then kerosene lanterns were used the rest of the night. Flashlights were issued to each ward and to all personnel as one never entered a darkened room because of snakes and other animals. Surgery and x-ray had a separate generator which could be used whenever the larger ones were not running.

Food was brought to the wards from the Chinese mess kitchen in 5 gallon cans and served by their own cooks. After each meal, the patients washed their bowls, chopsticks and cups in hot soapy water and rinsed them in hot clear water that was brought from the mess kitchen in large cans. This had to be strictly enforced because the patients would be found washing their mess equipment in unboiled water.

One always had to be on the alert for food brought in from the bazaars by visiting soldiers for it was all contaminated. Frequently we would find eggs, fruit and vegetables under a patient's blanket. Several times we even found them cleaning chickens and building a fire to cook them.

In less than a year we had a smooth-running hospital. It wasn't elegant but it served a great cause and we were quite proud of our efforts. But all things come to an end and after more than a year in our jungle hospital we moved on to establish another one farther into the jungle and left this one for a new unit to move into. At least we had the pleasure and satisfaction of establishing it and looked forward with enthusiasm to the new site and a lot of new experiences.

The Place of Nurse Attendants

THE much debated question of using attendants in hospitals that have schools of nursing is well answered by Christine Oddy, educational director of Maine General Hospital, Portland, who spoke on this subject at a recent meeting of the Maine Hospital Association. Miss Oddy stated:

"The trained paid aide or ward attendant allows the student nurse to carry on and develop those skills which are needed in giving effective nursing care. Undoubtedly, the attendant thus solves a nursing need and will help to meet the problem of providing adequate nursing care in this emergency.

"As a hospital primarily interested in educating students for professional nursing, we have thought seriously of the pros and cons of admitting subsidiary workers. We are primarily concerned with maintaining an open field for the professional nurse. Will the attendant prove a competitor to the professional worker?

"Anyone with vision will be able to see that the attendant will *not* compete with the professional worker. She is inadequately prepared to give competent nursing care in the hospital, the home or the custodial institution. Many will ask what nurse today will care for an elderly patient not acutely ill. But will the attendant have the ability to observe, recognize and interpret the nursing needs—mental, emotional and physical—of an elderly individual?

"If a hospital with a school of nursing finds it necessary to call upon subsidiary paid or unpaid workers and if they and the professional nurses can each grasp the significance of their services, then the community will receive better nursing care without sacrificing any standards."

A.C.S. Approval

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MANY hospitals today are short of equipment owing to wartime restrictions; many are overcrowded, and nearly all are short of personnel. To the administrators of these institutions it will seem rank heresy to state that none of these currently acute problems is the most serious one that must be met and overcome today. There is one that is more serious than any of these because it is of long duration and its roots are deep; it represents a definite hazard to the whole system of voluntary hospitals and to the free practice of medicine.

It is lack of cooperation, of mutual understanding and coordination of effort, of teamwork, of uniformity of purpose within the hospital organization.

Much Has Been Accomplished

Back in 1918, when the first survey by the American College of Surgeons was completed, few hospitals had the equipment, personnel and other facilities for the service which minimum standards have led us to expect today. A tremendous job has been accomplished as a result of the outlining of minimum standards for hospitals and the subsequent approval program of the American College of Surgeons.

For approximately twenty-five years, hospitals in the United States and Canada have been striving to raise the standards of patient care at least to a level consistent with these minimum requirements, which were drawn up only after careful study by a group of experts in the hospital field. The success of these efforts may be measured by the increase in the number of approved hospitals from 89 in 1918 to 3253 in 1943.

Most hospital administrators today are familiar with the visit of the representative of the American College of Surgeons. The purpose of the surveys made by these specially trained physicians is to determine the degree to which hospitals are meeting the minimum requirements. Although the program is entirely voluntary, with rare exceptions the college representative is cordially received. Constructive criticism is welcomed, as are any practical suggestions he may be able to offer for the correction of existing deficiencies.

Standards are specifically outlined for the various departments of the hospital; these are tangible factors and may be summarized briefly as follows:

1. Physical plant and equipment.
2. Ownership, control and management.
3. Medical staff: (a) selection; (b) organization, by-laws, rules and regulations; (c) appraisal of clinical work by regular and frequent conferences of the medical staff.
4. Medical records.
5. Various clinical and adjunct diagnostic and therapeutic departments.
6. Professional and nonprofessional personnel.
7. Teaching activities, if any.

These factors can be evaluated fairly accurately in the course of a thorough survey; from them an effort is made to determine the type and grade of clinical work being done in the hospital. The college representative must, however, develop a sixth—and possibly a seventh—sense with which to perceive the delicate shadings of the intangibles. These include underground strife within the ranks of the medical staff, failure to support the administrator or lack of interest in anything other than financial matters on the part of the governing board, ignorance, indifference or complete inability to cope with professional problems on the part of the administrator, be he doctor, layman or nurse.

This is strong language and should not be taken as an indictment of all hospitals or hospital management. On the contrary, it presents the gloomiest side of the picture. It is essential, however, that hospital management recognize that the tangible factors listed are not sufficient to assure the best possible care of the patient by the hospital.

The building and equipment may be the finest available; documents may indicate letter perfect medical staff organization; medical records may be voluminous, neatly typed and filed in orderly fashion; facilities for diagnosis and treatment may be unsurpassed, and personnel may be adequate in all departments. Yet the hospital may fail to fulfill its fundamental purpose.

The hospital is founded upon a humanitarian spirit; its primary objective is the restoration of health to the sick and injured. This cannot be accomplished unless the humanitarian spirit is shared fully by all who play a part in the operation of the hospital. It must take precedence over the earning of money; it, *not the wish to be included in a list of approved hospitals,* must be the basis of the desire to raise the standards of patient care within the institution.

Intangibles Must Be Recognized

It may be conceded, then, that certain intangible factors must be recognized and brought to life within the hospital if it is to function at its best. These, which too often are misunderstood, overlooked or occasionally deliberately ignored, might perhaps be outlined as follows:

1. Knowledge and understanding of hospitals and their problems by the governing board, particularly as regards professional problems.
2. Personality, training and experience of the administrator.
3. Actual, not paper, organization of the medical staff; loyalty and cooperation of this group.
4. Actual scientific value of the medical records; promptness and accuracy of completion.
5. Actual use made by the medical staff of the diagnostic and therapeutic facilities provided by the hospital.

Is NOT the Final Goal

High standards of patient care must be founded on a humanitarian desire to restore the sick to health—not on the mere wish to be on the A.C.S. "approved list"

6. Cooperation among the governing board, the administration and the medical staff.

7. General spirit of pride in and loyalty to the hospital among the personnel—from the top to the bottom of the hierarchy.

Let us review these briefly, one by one.

Perhaps we have tried too hard in the past to separate the professional aspects of the hospital from the lay administration. The average lay trustee and lay administrator admit that they know nothing of the care of sick people; this has resulted in a strong reluctance on the part of lay management to interfere in any way with the medical staff. Obviously, the administrator, or the trustee, if he is to accept the full responsibility of his position, should make it his business to learn about the care of the sick. This does not mean that he must study medicine; it simply implies that he should acquire a basic understanding of the objectives of the industry for the operation of which he is responsible. A staff composed of scientifically and intellectually honest doctors will welcome an opportunity to promote a better mutual understanding.

Administrator Is the Crux

In my opinion, the personality of the administrator is of the greatest importance. It is true that life will be easier for him and his associates in direct relation to his knowledge of his job. On the other hand, knowledge is wasted unless it is combined with executive ability, firmness, sympathy and understanding, a sense of humor and a desire to maintain the highest possible standards, primarily for the benefit of the patients in his institution.

Model medical staff by-laws, rules and regulations have little value unless they are enforced. Too often, they are formally adopted, then filed away and forgotten. It is the responsibility of the doctors to compile and adopt these, subject to the approval of the governing board. It then becomes the responsibility of the management to see that they are carried out. Paper and words have no meaning of themselves; it is only by acts in compliance with them that fine principles become significant.

Unless the medical staff meets regularly, at short intervals, and sits in judgment on its own work, there can be no proper evaluation of the standard of professional work being carried on in the hospital. In some hospitals, alas, these meetings are held with commendable regularity but accomplish nothing.

Professional jealousy, or a mistaken concept of professional ethics, restrains the doctors from constructive criticism of their own work and that of their colleagues. With proper study and analysis of clinical work, medical practice in the community will show improvement owing to the stimulation of scientific medicine by well-organized case discussions.

Over a period of time, success can be measured only as it is recorded, whether this concerns transactions involving sums of money or medical care involving human lives. It is often difficult to persuade doctors to acknowledge that the writing of a complete and accurate medical record for each patient under treatment by him is an essential part of giving that patient good medical care. The patient's present and future health, even his life, may depend on the promptness and accuracy with which a record is made of his current illness.

Too often, medical records are brief, incomplete and inaccurate, compiled—entirely from memory—weeks or months after the patient has left the hospital. How long could the hospital hope to function if the accounting records were kept by this method? It is imperative that the patient's financial account be accurate and complete at the time of his discharge—in order that the bill may be collected! Is the record of his health less important?

The finest laboratory is of no value to the hospital or the patient unless it is properly used. Proper use includes careful interpretation of reports by the attending physician. It is of little use to establish routine admission procedures unless the doctor evaluates them. Little benefit is derived from routine examination of surgical tissues by the pathologist unless his report is studied and compared with preoperative findings and diagnoses.

How much can be learned from the necropsy that is attended only by the pathologist? One would naturally assume that a report of sugar in the urine would result immediately in an order for a blood sugar estimation; far too often this and other tests indicated are not even ordered by the attending physician. This is poor medical practice, whether the doctor failed to note the original urine report or noted it and neglected to order the blood chemistry. This type of thing must be checked from time to time in order to evaluate properly the quality of professional work being done by the staff doctors.

How About Staff Morale?

Much has been said and written about the morale of the hospital personnel. It is a common error, however, to overlook the fact that the medical staff constitutes one group of the hospital personnel and that its morale is just as important as that of any other group. The trustees must have full confidence in, and loyally support, both the administrator and the medical staff. Respect and confidence must be mutual, but never blind.

It is essential that both the trustees and the medical staff understand hospital management. Trustees and administrator must have sufficient understanding of the medical care of the sick that they may be able to measure the service rendered in their

institution against the best available in the country. Reports of medical service should be submitted to the board each month, prepared with as much care and in as much detail as are the financial reports. Again, it might be emphasized that work pertaining to sickness and health, life and death of human beings should be recognized as being as important as work pertaining to dollars and cents.

The primary function of the hospital is the care of sick people. The management of finances, although vital to the operation of the hospital, is nevertheless an auxiliary function. If the trustees do not fulfill this primary function to the best of their ability, they are failing in their duty to the community just as surely—and more seriously—as if they wasted, lost or stole the money entrusted to them for the operation of the hospital.

The doctor must understand that he is not required to attend staff meetings and write medical records only because his hospital will not be approved if he fails to do these things. It is true that he receives no direct remuneration for many of the services he renders to the hospital. How much thought has been given, however, to the indirect benefits he derives from his association with the hospital?

Suppose the doctor were required to provide, in connection with his office, facilities for hospitalizing his patients, with all the attendant and accessory services entailed. Suppose he had to equip and staff an operating room, an x-ray department, a complete clinical and pathological laboratory, not to mention providing a nursing staff and such services as housekeeping, maintenance, laundry and dietetics.

It is a well-known fact that the cost per patient day decreases as the number of patients increases. Consider for a moment the terrific cost per patient day, in addition to the original capital outlay, if each doctor had to provide such service for his own patients! Consider the saving in time, effort and dollars, when he makes rounds in the hospital, seeing six patients in one hour in place of making six scattered home calls. These are concrete benefits and might even be reduced to actual figures, preceded by a dollar sign.

So we come back to our original premise, that the successful operation of any industry depends upon the cooperative effort of many individuals and groups of individuals to achieve a common objective. If that objective is to examine, treat, comfort and cure sick people, the industry should certainly be operated on a level of maximum, not minimum, standards of service.

If in all hospitals the administration and the personnel, including the medical staff, could face this issue fairly and honestly, there would be no further need for extramural stimulation to raise standards. For within the walls of the hospital there would develop a spirit so fine that the quality of service rendered by all concerned would be always beyond question or doubt.

You say this is Utopian? Perhaps it is, a little, but if we cannot reach perfection, we can at least strive for it. Let's give it a try.

An Occupation Is Sound Therapy

GERALDINE R. LERMIT
Director
St. Louis School of Occupational and Recreational Therapy
St. Louis

"TIMELINESS," consciously or subconsciously, largely determines our thoughts and actions, and there are always the outward, visible signs that give us the indications of this timeliness. Perhaps there is no clearer clue to timeliness than the words that are current in a period. At least, they serve as indications of current thought and point the direction in which action may develop.

Rehabilitation, reconditioning, reconstruction, reorientation, reconverting—re-, re-, re- —*ad infinitum*. These "clue" words are poignantly expressive of thoughts of today that, it is devoutly to be hoped, will become actions of tomorrow.

In all fields of science, timeliness is a dominant factor; in the science of medicine, it is the very essence of good treatment, the therapy that effects results. A physician's opportunity to effect results is definitely limited by this element of time. A patient is his physician's case only as long as he is sick and convalescing. Among the therapies available to the physician of today, and one that is actually desired by the patient, is occupational therapy, aptly defined as "any activity, mental or physical, prescribed as treatment."

The efficacy of any treatment depends in great measure upon the time when the condition of the patient indicates the need for its application. It has been accepted without question, too much so in fact, that occupational therapy is indicated in the period of convalescence, especially when a prolonged period of convalescence is involved.

For years, physicians have recognized and prescribed this treatment even if for nothing more than the morale of their patients, but today a new and greater significance is attached to occupational therapy, primarily as a result of the accelerated need for returning war casualties to military duty as soon as possible.

There is a shortage of manpower, especially of trained manpower, and it has become necessary to restore such casualties as can be restored as

rapidly as possible, so that they can return to fill the place for which they have been specifically trained. In all programs of convalescent care, reconditioning and rehabilitation, occupational therapy is accepted as an essential treatment.

No longer is it administered just for "morale"; as soon as possible, frequently within the first forty-eight hours, the physician prescribes, and sometimes himself administers, this therapy. The need for the acceleration of his patients' restoration has already turned more than one able physician into an ingenious occupational therapist!

There Are Many Ingredients

In occupational therapy there is a never-ending variety of ingredients that may compound the prescriptions used in this form of treatment, and therein lies much of the skill and satisfaction that brings the desired results to both the physician and the patient, as well as to the therapist. From sculpture to Spanish, from music to mechanics, from the broad fields of education and recreation, the ingredients of this therapy may be drawn, must be drawn, for each case to be treated is an individual case.

It is well to remember that convalescent treatment begins at the bedside and carries through to the time of restoration, whether that restoration is to military duty or to civilian responsibilities, and it is both wise and well to remember that the effects of hospital treatment should not and do not cease when a patient leaves a hospital.

Effectiveness Will Increase

Perhaps it is not too far-fetched a comparison to prognosticate that as the sulfa drugs, penicillin and plasma have added to the effectiveness of chemotherapy, so will the ingenuity and understanding of physicians and therapists in devising ways to meet the needs of their patients add to the effectiveness of convalescent care.

The old concept of occupational therapy, "any activity, mental or physical, prescribed as treatment," has not changed and convalescence is still the period indicated for its greatest efficacy, but it is prescribed much earlier in the program of the patient's hospital care, and in more varying form, and is more explicit in its application to patient needs now than was true in World War I.

Speculating upon this development leads one to conclude that the physician may have been responsible for it. In World War I, there was little recognition of occupational therapy as an integral part of a patient's treatment. It was accepted by most physicians as a harmless palliative, and for the most part it was requested by the patient himself and the physician kindly acquiesced to his patient's desire. However, to the Reconstruction Aide, the occupational therapist of World War I, upon whom devolved the responsibility of administering the treatment, there was no lack of understanding as to its efficacy going far beyond the palliative and many a record buried in the hospital files could so testify.

Not infrequently a patient's improvement is noticeably determined by his "confidence in his doctor," and there is no stage when this relationship is of greater importance than in the period of convalescence. The treatments prescribed by his physician at this time may be more effective in producing the patient's cooperation and restoration through his participation in his own treatment than those prescribed at any other time.

The physician of today is perhaps no more alert to this fact than was the doctor of yesterday, but a greater number and variety of services are more readily available to the modern physician in a modern hospital. Not only wards, operating rooms and laboratories but numerous other facilities, such as physical therapy, x-ray and radium therapy, occupational therapy (with its workshops as well as its ward services and recreation rooms) and social service departments, are available today.

If, as a well-known doctor has pointed out, man's three basic needs are "society, work, love," there is ample means of employing them for the treatment of patients in a modern hospital. All our military hospitals have been planned to meet these needs and are being staffed with the necessary personnel. The physician in World War II has many forms of therapy available that were not available to the physician of World War I.

Never before in the history of man has the problem of convalescence assumed such magnitude and complexity. Millions of men and women, whole nations in fact, are indeed "sick in mind, body and estate." Where nations are concerned, employment, "a job for everyone," is the accepted panacea, and the opportunity and means for furnishing it are paramount considerations in all planning. Even more for individuals than for nations, employment, a job, an occupation, is of first importance and the soundest therapy.

The convalescent period of war casualties—and many of them will be civilians—will be long and difficult. Medical science has advanced far, especially in the care of bodily injuries, and yet the convalescent period is often a matter of months and years. Although medical science has also advanced in the care of the mentally injured, the enormous number and complexity of cases already returning are taxing to the utmost the strength and skill of physicians, families and friends.

In the care of both physical and mental injuries, occupational therapy has taken its place as a vital treatment. It has one unique quality that other treatments lack—the better the patient becomes, the more of it he can take. Another quality of high value is that it is active—the patient participates in his own treatment. Still another valuable asset is the inexhaustible and varied source of supply for its application.

Unlike the missing quinine and the sulfa drugs and penicillin, this ever-varying form of treatment can be compounded from practically anything. "Any activity, mental or physical" covers a very wide range.

The Press Is Taking Notice

It may be significant, at all events it is noteworthy, that much attention has been given to the problem of convalescent needs by the press lately. Numerous articles are constantly appearing with such titles as the following: "Convalescent Care in Air Force Hospitals," "Industry's Part in the Hospitals," "Hobbies of Service Men" and "Recreational Programs."

Whatever it is that has called forth this attention on the part of the press, perhaps it is no more than the "human interest" appeal, it has nevertheless brought about recognition not only by the physician but by the layman that occupational therapy is a vital part of the patient's treatment in the period of convalescence.

X-RAY EXAMINATIONS ARE IMPORTANT IN PREVENTION

Here, They Practice PREVENTION

ELEANOR LEE HEARON
Director
Medical Social Service
University of Colorado

HOSPITALS are becoming more aware of their community responsibilities and the need of the hospital to accept its part in social and community planning. The preventive medicine clinic at the University of Colorado School of Medicine and Hospitals is an extension of the hospital service into the community and an example of a new venture in community responsibility.

Some of the members of the hospital staff have become aware of existing problems. Where can the well, or supposedly well, patient be examined? How best can patients receive an adequate evaluation of their physical and mental capabilities? Is a physical and mental examination a basis for any rehabilitation plan? How can people be kept as well as possible? Can immunizations and other public health measures be provided for patients?

These are questions that have come up time and again. The social service department saw evidence day by day of patients, clients from social agencies and others, who could benefit from a preventive medicine program. The war and its complications only accented the need for such a program. General objectives were set down:

1. To keep people well through proper examination and remedying of conditions that develop into illness.
2. To examine patients on a basis for rehabilitation, employment or living. To keep people at their maximum physical capacity for production in industry or efficiency in the home.
3. To evaluate the patient's capacity to do certain types of jobs from both the physical and mental standpoints.
4. To explore and develop at the university a preventive medicine service which could be of value to the community.

It was seen immediately that such a program would be costly and that extra financing would be needed. The social service department had been asked by the Junior League of Denver to suggest possible projects that would offer real community service and utilize volunteer assistance. This project was chosen by the medical school to submit to the Junior League, which has in past years contributed much to the welfare of Denver through demonstration projects and volunteer services.

The league voted to sponsor the preventive medicine clinic and voted the University of Colorado School of Medicine and Hospitals $10,500 for a three year demonstration. Only through cooperation of the league were we able to embark on such an enterprise. A written agreement was drawn up, signed by both parties, and an advisory committee comprised of league members and hospital staff was set up.

There have been many problems owing to personnel shortages, especially of physicians, problems caused by war difficulties, the concern of medical societies that such ventures would threaten private medical practice and eligibility questions. However, at the end of two years some progress had been made. The clinic meets five afternoons a week. The staff of the clinic is composed of two physicians, a social worker and a nurse on a half-time basis, appointment and admission clerk and a full-time laboratory technician.

The examination includes the following laboratory tests: complete blood count, urinalysis, sedimentation rate, Wassermann reaction and chest plate (4 by 5 inches or a larger one if indicated); vision tests, color, near and far; audiogram; history and physical examinations and where indicated, immunizations; psychiatric evaluations, psychometric and aptitude tests, and consultations in the specialties. The clinic is diagnostic and patients are referred either to their physicians or to the outpatient department.

The patients have been the "hospital family," *i.e.* medical students, nursing students, dietitians, student technicians and hospital employes. Several other groups have been examined. The Denver Orphans' Home sends all its employes and pays a nominal fee to cover the cost of their x-ray tests and laboratory work. With the high turnover in maintenance help this has resulted in

a constant flow of patients from this institution. The household workers are examined at the request of a local committee sponsored by physicians and social agencies.

One summer 400 men in a local pipe and steel company were examined and recommendations were given this company for the development of its own health program. Individual clients from social agencies are referred for an evaluation of the possibilities of their rehabilitation.

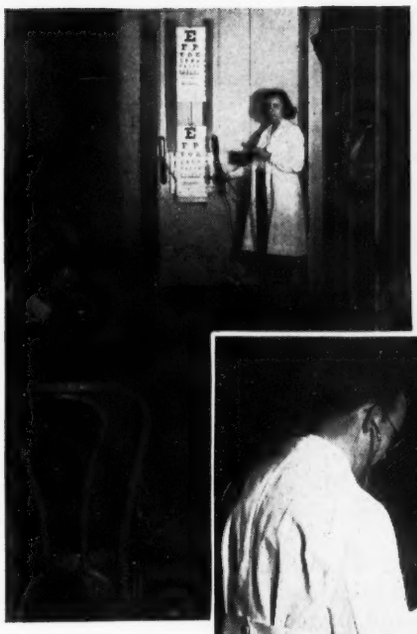
The Colorado Workshop for the Blind to which have been delegated the training and placement of the visually handicapped is going to use the clinic for the preplacement physical and mental appraisal of these men. We hope to utilize the modified psychometric and aptitude testing for this group that has been devised by the Trainee Acceptance Center of the Philadelphia Board of Education.

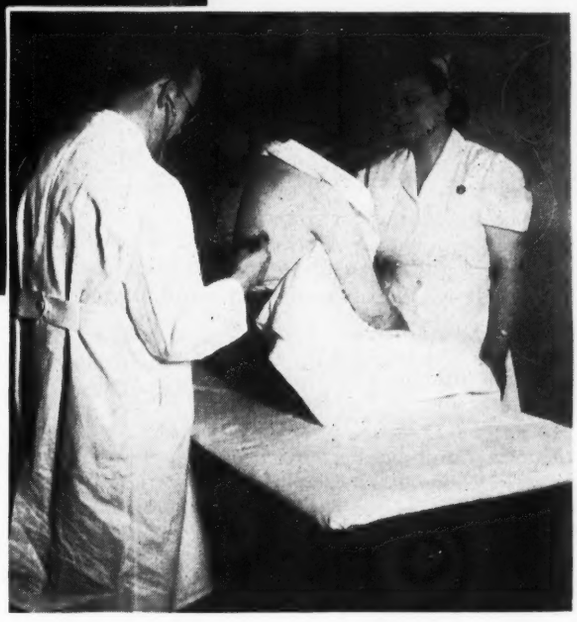
Discharged veterans are being referred here by the U.S.E.S., some through personnel directors in industry, some from the information service of the Council of Social Agencies and some from other organizations. Those who are applying for medical education under the G.I. Bill of Rights are sent through the clinic and in this group a psychiatric evaluation and Rorschach test are routinely done. The Civil Service Commission refers others who are unemployed and need a physical examination report before placement.

Members of a professional and business women's club in a near-by county have been sent for health examination at the request, and with the permission, of the local county medical society. Examinations of the tuberculosis contacts and of those patients whose chest plates require further evaluation before diagnosis are probably to be referred through the local tuberculosis society, which is cooperating with the mobile x-ray unit of the state health department.

We are examining prospective foster and adoptive parents for the Children's Aid Society.

Although this seems like a wide variety of patients, it is readily seen that all need an adequate physical, mental and social appraisal to serve as a basis for prevention and correction of illness, rehabilitation for employment and a method of helping each individual attain the maximum of his capacity for self-maintenance.





A thorough physical checkup, eye tests, laboratory tests, psychometric and aptitude tests are important in the hospital's program of prevention.

Case illustrations could be endless. There was the hospital employe who was found to have a condition that prevented his continuing his job. A readjustment of his job was made and assistance was given to help him face this situation and to continue his employment which was essential to the patient and to the hospital. A veteran was found to have a remediable condition the treatment of which resulted in his procuring a job which paid well and was more satisfactory.

Then there was another discharged veteran who had suddenly lost his vision in one eye and for whom eye care was recommended with the hope of restoring partial sight. In order to carry out the treatment recommended it was advised that he should not work and financial aid was procured through the Red Cross until his compensation claim was reopened on the basis of the eye findings.

Another example is a blind Negro girl who was graduated from a southern state school last year and has tried to earn her way by singing at church socials. She showed a capacity to be trained for a job which should make her self-supporting and in which she would not capitalize on her blindness.

Several cases of rheumatic fever (acute) were found in persons who were working daily and who had no knowledge of their disability. An early cancer of the lip and diabetes not previously known by the patients are only a few of the conditions found, the treatment of which would result in preventing needless incapacity and will keep these patients "on the job."

One of the important factors of this clinic is its value to medical and nursing students as it gives the students an opportunity to understand the necessity of examining the well patient. This demonstrates teamwork between physician and social worker, affords an understanding of the importance of physical examinations as a basis for rehabilitation and shows the relationship of the social, medical and mental aspects of the problems of supposedly well persons.

The cooperative efforts of the Junior League of Denver and the University of Colorado School of Medicine and Hospitals have been stimulating and helpful. The deep conviction of all who are a part of this clinic that it is worth while and must be of a real community service demonstrates that hospitals are conscious of the needs of people in their communities.

About People

Administrators

Leo G. Schmelzer, assistant administrator of the Wisconsin General Hospital, Madison, Wis., since 1933, has been appointed superintendent of George Washington University Hospital in Washington, D. C., a 400 bed hospital to be built by the government for the use of the university to meet the needs of the war-time emergency in Washington. He will supervise the construction and equipment of the new building which will be erected on the site of the old structure and will manage the hospital after it has been completed.

Mr. Schmelzer was business manager of Wisconsin General Hospital from 1928 to 1933 and executive secretary of the University of Wisconsin Medical School from 1938 to 1940. He was chairman of the A.H.A. committee on architectural plans of the Council on Hospital Planning and Plant Operation and chairman of the A.H.A. committee on architectural standards for hospitals. He has been a fellow in the A.C.H.A. since 1938.

Rev. Clarence L. Braun, formerly superintendent of Evangelical Lutheran St.. John's Orphan Home in Buffalo, N. Y., is the new administrator of De Graff Memorial Hospital, North Tonawanda, N. Y.

Dr. Carl E. Muench, superintendent of Crouse-Irving Hospital, Syracuse, N. Y., has been made medical director of the hospital. **Dorothy Pellenz,** formerly assistant superintendent, will replace Doctor Muench as superintendent. Doctor Muench has been a member of the International Hospital Association and the A.C.H.A. since 1939.

Rev. John G. Benson, who has served as superintendent and general secretary of Methodist Hospital, Indianapolis, Ind., for fourteen years, has resigned as superintendent. He will continue as general secretary of the hospital and **Rev. O. L. Fifer,** former editor of the Cincinnati edition of the *Christian Advocate,* will be acting superintendent until Reverend Benson's successor is named.

William B. Seltzer, superintendent of Bronx Hospital, New York City, since 1930, has been appointed superintendent of Mount Sinai Hospital, Cleveland, succeeding **Dr. Harry L. Rockwood.** He will assume his new duties June 1.

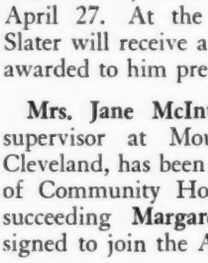
Dr. T. L. Williams has been appointed administrator of Kadlec Hospital, Richland, Wash.

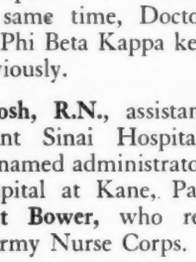
Dr. S. A. Slater, superintendent of Southwestern Minnesota Sanatorium, Worthington, Minn., will receive the honorary degree of doctor of science from the University of Richmond, his alma mater, at a special convocation April 27. At the same time, Doctor Slater will receive a Phi Beta Kappa key awarded to him previously.

Mrs. Jane McIntosh, R.N., assistant supervisor at Mount Sinai Hospital, Cleveland, has been named administrator of Community Hospital at Kane,. Pa., succeeding **Margaret Bower,** who resigned to join the Army Nurse Corps.

Elizabeth I. Hansen, R.N., was appointed administrator of Fairview Hospital at Great Barrington, Mass.

Norman E. Snyder, assistant superintendent of Gregg Memorial Hospital, Longview, Tex., for twelve years, has been appointed superintendent of the hospital. Mr. Snyder is also assistant director of the Gregg County venereal disease clinic.



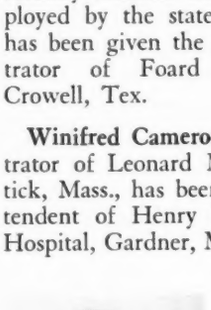


Left: Mrs. Estelle Massey Riddle, appointed to the faculty of New York University (see page 144). Right: Dr. Robert F. Brown, newly appointed medical director of St. Luke's Hospital in Chicago.

Grace A. Knight, R.N., director of the school of nursing and superintendent of nurses at Methodist Hospital, Madison, Wis., has been named administrator of the hospital.

Julia B. Kociela, R.N., formerly general duty supervisor for Wichita General Hospital, Wichita Falls, Tex., and more recently venereal disease clinic nurse employed by the state health department, has been given the position of administrator of Foard County Hospital, Crowell, Tex.

Winifred Cameron, formerly administrator of Leonard Morse Hospital, Natick, Mass., has been appointed superintendent of Henry Heywood Memorial Hospital, Gardner, Mass.



Thompson D. McCrossin has been elected superintendent of Presbyterian Hospital, Pittsburgh, succeeding **Mary B. Miller,** who has been superintendent for twenty-five years. Mr. McCrossin has been associated with Presbyterian Hospital for seventeen years and has been assistant superintendent since 1938. He is a member of the Hospital Association of Pennsylvania, the A.H.A. and the A.C.H.A.

Mrs. Alma I. Schiek, R.N., has resigned her position as superintendent of Greenville Hospital, Greenville, Pa., to accept the post of superintendent of Franklin Hospital at Franklin, Pa. She succeeds **Mrs. Catherine Kunzel** who resigned March 1.

S. R. Mitchell has assumed the duties of superintendent of Laconia Hospital, Laconia, N. H., as successor to **Albert F. Doloff,** now administrator of Charlotte Hungerford Hospital, Torrington, Conn. Mr. Mitchell was at one time superintendent of Malden Hospital, Malden, Mass.

Department Heads

Adelaide C. Ecclesine has been appointed director of the newly established public relations department at New York Foundling Hospital, New York City.

Robert L. Zucker, formerly of the Franklin County Tuberculosis Hospital

(*Continued on page* 144)

Medical Records were never so valuable

EDNA K. HUFFMAN
Medical Records Librarian
Wesley Memorial Hospital, Chicago

Thus times do shift; each thing his turne does hold;
New things succeed, as former things grow old.

—HERRICK

WAR-TIME conditions, resulting in a shortage of doctors and nurses, have not altered the necessity for complete and accurate records. Procedures must be simplified to be sure but the high quality of the records must be maintained.

So important do the Army and Navy medical departments consider accurate and adequate medical records that they require them to be completed daily. Procrastination, such as we find in our civilian hospitals, is not tolerated. *Every* task must be done *every* day.

A committee has been created by the federal government to formulate a comprehensive program for the compilation and preservation of medical records. A thorough study is to be made of methods used in creating and administering such records in the various agencies, the location, character, quantity and content of the various bodies of records now in existence and the nature and extent of the use that will be made of them in the future.

Government Sets the Example

This committee will recommend the records to be preserved and will outline the best methods of administering them so as to utilize their maximum scientific and administrative value. When our government places such a high value on medical records, should not civilian agencies place an even higher value on them?

A record of the physical condition of the patient, the treatment given and the progress of the case has been kept in some form since the days of the stone carvings on the walls and the hieroglyphics on the papyri. Such information was of great value in the compilation of the early textbooks on medicine.

Complete and accurate medical records are now being used as the basis for comparison of the reactions of various illnesses to the methods of treatment and the therapeutic agents used. If it were not for such case records there would be no way of knowing whether maximum results had been obtained or whether advances had been made in the light of present day medical knowledge.

The use of medical records has also for many years expedited the teaching of medicine. There is no more efficient method of teaching than the citing of cases to illustrate the subject under consideration. The truth or fallacy of a medical hypothesis can best be proved from the information contained in the records.

Especially in time of war, when living conditions are abnormal and we are under extraordinary mental stress, it is essential to have complete medical records. Means of treating the new mental and physical diseases which are appearing must be devised constantly. The continual shifting of both civilian and military personnel is spreading disease from one locality to another. Our returning armed forces are bringing in, from foreign lands, diseases heretofore unknown in this country.

We shall not be giving our patients the best possible care, in future years, if we do not now compile and preserve accurate and adequate medical records showing the reactions of our patients to the treatment of mental and physical injuries. Incomplete medical records in the event of subsequent illness of such patients would prevent knowledge of previous conditions and illnesses and of the therapeutics used, any or all of which might be vitally essential at the time.

The medico-legal aspect must be kept in mind even more today than ever before because of the constantly shifting war-working population. Such population is concentrated in large industrial centers and is exposed to many illnesses and injuries. For this reason every hospital and every medical staff should have the protection of complete medical records.

"Paper Work" Is Irksome

Staff men are exceptionally busy in these times. The so-called "paper work" which they found tedious and irksome in normal times becomes increasingly so now that extra burdens are placed on those left to carry on while the younger men are in the armed forces. We must find ways and means, therefore, to keep up the required standards. It will require extra effort on the part of everyone concerned. Our men who are gone are doing their utmost to preserve our way of life and we should do likewise on the home front.

The October 1941 issue of the *Bulletin* of the American College of Surgeons on page 303 states:

There should be no letting down of standards despite the emergency through which we are passing at present. No patient is assured safe treatment where there is no recorded case study in which the diagnosis is clearly stated and supported by findings so that treatment may be administered on a rational basis. No physician, be he general practitioner, internist, surgeon or specialist of any kind, can practice medicine scientifically without carefully and properly recorded data on each patient whom

he cares for in the hospital. He is not a safe practitioner of the healing art unless he has the concept of and belief in all that is involved in an accurate and complete medical decord.

Records must be kept up to date during the illness of the patient. If left until a later time, essential information is often forgotten or omitted in the stress of the work at hand. Adequate leadership by the medical records librarian will assist in prompt recording. It is her responsibility to develop the necessary cooperation and collaboration so essential at such a time.

The physician has a real stake in the medical records of his patient although it may be difficult for him to appreciate the fact when he is under pressure. The medical records librarian must learn to steel herself against the rebuffs she meets when trying to obtain the necessary cooperation. Such rebuffs are but a normal reaction to the stress of the times in which we are living. Personalities are not being considered.

Records Librarian Must Help

Most hospitals are experiencing a shortage of interns and residents. These institutions must devise ways and means to assist the busy physicians in completing their records. An examination loses its value if it is not accurately, promptly and permanently recorded. Assistance can be given by providing secretaries and/or recording devices. Secretaries can be, and in many instances are being, provided to make rounds with the busy physicians, making notes as they go to be transcribed later and signed by the physician on his next rounds.

Dictating machines may supplement secretaries. Thus, when the secretary is busy with one physician, another may use the dictating machine while information is still fresh in his mind. Some hospitals have even gone so far as to provide a dictating machine at every chart desk. Hospitals that provide such assistance to the physicians realize that medical records are the gauge by which the efficiency of the medical service rendered by the hospital and its personnel is measured.

In the past many hospitals have required the signature of the physician in numerous places on the chart. This may be simplified by providing a place on the front or summary sheet indicating that the signature is affixed in approval of the chart as a whole. The surgeon should sign the operative record. In those hospitals in which the physician signs for the narcotics on the order sheet, this will, of course, have to be continued to meet the requirements of the narcotics laws.

To save time for the medical records librarian the disease, operation and physician's index cards may be totaled each year, carrying each card on as a perpetual index. Statistics will be more readily available and the time spent in making new headings for the cards at the beginning of each new year will be saved. A unit patient's record will save time, regardless of whether the serial or the unit system of numbering is used, when a physician is in a hurry for all the records on a particular patient.

Careful study of the statistical reports emanating from the medical records library may reveal a duplication of data that can be eliminated. This cannot be done, of course, with reports that must be sent to the various state or municipal agencies, but it can be done with those compiled for use within the institution.

By making a job analysis for the workers in the medical records department, or even for herself if she works alone, the librarian can increase the efficiency of her department. She will be able to devise ways to eliminate certain duties and combine others, thus freeing more time in which she can assist busy physicians. Many medical records librarians have in the past duplicated various phases of work in their departments for no other reason than that "it has always been done that way." Then there are others who have been duplicating procedures without realizing it.

Simplify the Work

Now is the time, with the manpower and womanpower shortage upon us, to make the needed changes so that our departments will be more efficient. Simplification leads to accuracy. An accurate job analysis, and a careful study of it, by the medical records librarian will reveal such duplications, if there are any, and point the way to eliminations or at least to combinations of duties that will simplify the work of the whole department.

When this great holocaust is over, young men who have been graduated from our present day accelerated medical courses will be coming back and will seek further study. The older men who left well-established civilian practices will be coming back wanting refresher work in general medicine after a one-sided experience of mostly traumatic surgery. These are problems that will be confronting the hospitals, as well as the medical profession.

The medical records librarian must, as always before, assist in providing and having available at all times accurate, adequate medical records for the benefit of the physician and for medical research, and also for the patient and the hospital. In addition, she should have the added incentive of doing all this so that such records will be available for the returning men to enable them to brush up on the illnesses with which they will have to deal in their private practices.

"Equanimitas"

IF EVER the hospital administrator needed to seek out and read Osler's little essay on "Equanimitas" it is now. He will surely find there an inspiration to adopt a judicial attitude of imperturbability, no matter what happens.

Every day brings occurrences which on the previous day seemed impossible.

A key person, hitherto considered indispensable, leaves. At the first shock, the administrator is inclined to believe that his whole organization is about to collapse. Still he must carry on.

Supplies cannot be obtained. Apparatus and machinery wear out and cannot be replaced. The future of the voluntary hospital appears clouded. Patients and board members are irritable, difficult to please. Still the administrator must carry on as best he can.

Osler's advice to do the day's work in the best possible way and let tomorrow take care of itself is a fine golden text for the average hospital worker. Equanimity means placidity, belief in the future and, above all, a consistent refusal to descend to personalities.—JOSEPH C. DOANE, M.D., *medical director, Jewish Hospital, Philadelphia.*

"O. K. Is the Blue Cross"

K. A. KIRKPATRICK
Hospital Service Director
Minnesota Farm Bureau Federation, St. Paul

THAT the Blue Cross is O. K. is the solid opinion of some 32,000 Minnesota Farm Bureau Federation members and their families who have Blue Cross through 345 farm bureau units spread throughout 65 of Minnesota's 87 counties.

Why? Well, after some five years of studying various hospital insurances, farm bureau members decided that Blue Cross nonprofit, no broker, no commission, no adjuster-expense kind of operation had the edge on all the other types of hospitalization plans.

Plans Deliver the Goods

You see we'd been watching the Blue Cross delivering the goods to some of our relatives in our cities and small towns for quite a while and we liked the way it catered to persons of moderate means; the way it emphasized budgeting for health care; the way it accented organized self-help. We liked the fact that it didn't pay brokers or agencies for "getting the business" and that it paid dividends only in services. Especially, we liked the way it promptly delivered hospital care when it was needed. We decided that Blue Cross was the plan for us.

The history of the hospital service project of the Minnesota Farm Bureau Federation tops in human interest the hundreds of other services to agriculture that have been performed by the farm bureau in the last quarter century. It started like this. After four years of talking hospitalization schemes, members of the Four Town Unit in Hennepin County decided to do something for themselves about freedom from worry when illness came. They called for and heard a presentation of the Blue Cross plan. Then 42 members signed up.

Before long, a few of the 130 persons protected under these first Blue Cross contracts had occasion to test the plan. Blue Cross passed the acid test and stories of hospital bills paid by the Minnesota Hospital Service Association without fuss or bother spread quickly through women's community committees, *Farm Bureau News,* conferences, regional and annual meetings and, before we knew it, other farm bureau units in distant counties were saying, "Why can't we have Blue Cross in the same way that Hennepin County does?"

By 1941 the demand for the Blue Cross service was so widespread that it became a matter for discussion at the annual meeting of the Minnesota Farm Bureau Federation. The federation's county delegates voted unanimously to establish aggressive cooperation with the statewide Blue Cross plan and to adopt a program of work designed to make Blue Cross avialable to farm bureau members wherever they were eligible.

Before 1941 was over, 29 farm bureau units in 13 counties had signed up for Blue Cross to protect a total of 1954 persons, and our "aggressive cooperation" has taken us a long way since then. In fact, during the summer of 1941 it became necessary to appoint a full-time director to work with the health and hospitals committees of the farm bureau which are responsible for organizing Blue Cross-farm bureau enrollment throughout the state.

We still have a few boys, however, who sit back and say to any worker who will listen, "Yeah, this hospital care idea's all right, but the farm bureau officers should have set up our own hospital, medical and surgical insurance company when they started this thing. I don't think I'm interested in this hospital stuff. It doesn't cover enough."

We answer these boys patiently, but firmly. We tell them that, in the first place, the farm bureau officers didn't start this group hospital service; that it is the outgrowth of the thinking of farm bureau members acting for and by themselves. We tell them that our farm bureau members' experience with Blue Cross has undeniably demonstrated its value and its freedom from "gold bricks."

We point out to them that for the twelve years the Blue Cross has operated in Minnesota, 81 cents in every dollar has gone back to the subscribers in actual hospital service benefits; that the Blue Cross plan operates on 13 per cent of its income, and that 6 cents of every hospital service dollar is laid aside for adequate contingency reserves for emergencies. Finally, we remind them that the farm bureau, by its annual program of work, is pledged to organize Blue Cross groups in every farm bureau unit that's eligible for the service and to promote and to insist on a "social security" that preserves the entity of the individual, his family and his local responsibility.

A great deal of the credit for the remarkable growth of farm bureau-Blue Cross enrollment must go to the health and hospitals committees. Besides organizing Blue Cross hospital service groups in local farm bureau units, these committees keep themselves informed on the planks in the "health" programs of the federation and interpret and translate these planks into action in their respective counties and local communities.

Encourage Hospital Participation

In addition, they investigate and certify farm bureau member applicants for hospital service contracts if such certification is necessary. Often, they point out to local hospital management boards the advantages of nonprofit operation and the committees, taken in a body, have in the last five years interested many local hospitals in affiliating with the voluntary Blue Cross plan, so that farm families in the areas might be eligible along with other village and rural people for Blue Cross protection.

Yes, the Blue Cross plan and the Farm Bureau Federation have established a happy relationship in Minnesota and the longer we work together the more farm bureau members there are who say, "O. K. is the Blue Cross."

Eight Hospitals Tell Their Plans for the Future

APPARENTLY, small hospitals either do not have many plans ready yet for the postwar period or are not willing to talk about them at present. This conclusion seems to be justified by the fact that only eight of the 50 questionnaires sent out on this subject were returned to The MODERN HOSPITAL.

Of the eight that were returned, all have some sort of plan for changes to be made soon after the war is over.

Most of the changes refer to the hospital building. Three of the institutions are planning new and larger hospitals. Langdale Hospital of Langdale, Ala., reports that it has the money and land ready now for a 100 bed hospital to replace the present 25 bed institution.

A new elevator, a new nurses' home, additional buildings, a new kitchen, new refrigeration and new laundry equipment are among the other building changes that are now being planned by these eight small hospitals.

Garfield County Community Hospital of Glenwood Springs, Colo., is planning a group of small cabins with central heating and call system where old people who do not need hospitalization can live comfortably by themselves with necessary supervision and care. "There is no home for old people in the county where they can live and be supervised," writes Mrs. Elsie H. Sample, superintendent. "Hence the need for such a housing system. This hospital could then be used to care for more patients who are ill." This institution is also planning a nurses' home after the war.

The most extensive program is reported by David R. Kenerson of Clearfield Hospital, Clearfield, Pa. He writes:

"Our plans for the hospital are based on the recommendations of Charles F. Neergaard, hospital consultant, who was recently engaged by the board of directors to advise us on our long-range planning for the hospital. According to these plans, we expect to construct a connecting wing between the fireproof maternity building and the old hospital building, to provide modern bed space for some of the patient accommodations in the old building.

"The ultimate plan is to construct an additional wing on the other side of the maternity building and eventually do away with the present main hospital building so as to provide a new fireproof hospital on the present site. As the ultimate completion of this plan in its final stages is five or six years in the future at least, we shall continue to maintain and improve existing facilities in the hospital building."

The second question asked the hospitals what changes are planned in services to patients. Some of these, of course, are indicated by the building programs outlined. Others include: the organization of a pediatrics department and an isolation department at St. Mary's Hospital, Enid, Okla., and the building up of the out-patient department and organization of a physical therapy department at Clearfield Hospital. A new and improved method of meal service is contemplated at the Miramichi Hospital, Newcastle, N. B. This will await the construction of the new kitchen, doubtless.

Few changes in relations to hospital personnel are being definitely planned by these eight small hospitals. Miramichi Hospital will provide housekeeping equipment to make the daily work easier and more efficient, according to Beatrice M. Hadrill, superintendent. Mr. Kenerson has an interesting idea:

"It has seemed to me that better relations with hospital personnel would be possible if the hospital assumed the obligation of publishing a monthly bulletin. While this does not take the place of sound personnel practices, it does seem to me to offer an opportunity for keeping before the employes the aims and objects of the hospital and keeping them informed of the current problems and current progress."

Two hospitals mentioned plans for changes in hospital finance. Miss Hadrill says that "better understand-

THANKS TO THESE CORRESPONDENTS

HOSPITAL	ADMINISTRATOR	BEDS
Langdale Emergency Hospital, Langdale, Ala.	Ruby Carver White, R.N.	25
Garfield County Community Hospital, Glenwood Springs, Colo.	Elsie H. Sample, R.N.	30
Charleston Hospital, Charleston, Ill.	Harriott Baily, R.N.	32
Nebraska Masonic Home, Plattsmouth, Neb.	William F. Evers	50
Miramichi Hospital, Newcastle, N. B.	Beatrice M. Hadrill	50
St. Mary's Hospital, Enid, Okla.	Sister M. Lucille	75
Lutheran Hospital, Fort Dodge, Ia.	O. A. Rusley	118
Clearfield Hospital, Clearfield, Pa.	David R. Kenerson	120

ing with the county council in regard to the payment for indigent patients will be sought. At present there is a county grant which does not adequately reimburse the hospital for the work done."

Mr. Kenerson's plans cover a wider range:

"The hospital is supported now by the paying patients, by an appropriation from the state for the care of indigent patients and by contributions from individuals and the local Community Chest. The county government has not yet assumed any obligation for contributing to the support of the hospital but we are hopeful that this may come about. The continued growth of the hospital service plan in this area will continue to benefit the hospital and its clientele. We are debt free. It is quite likely that in the immediate postwar period a solicitation for capital funds will be necessary for new construction."

Regarding public relations plans, these two administrators again were the only ones with any comments. Miss Hadrill says that her hospital now has fairly good public relations "but the education of the public to the realization that it has a responsibility in the payment of its accounts is an uphill road."

Mr. Kenerson says: "There has recently been formed a committee on public relations as a standing committee of the board. While this has not functioned as yet, we expect to have it operating regularly in the coming year. The purpose of this committee will be to give long-range planning and guidance to the administrator for carrying on a consecutive program of public education. With the improvement in the physical plant at the hospital already made and with sound personnel relations with the regular hospital employes and the medical staff, we shall be in a position to get across to our community the purpose for which the hospital stands.

"Tied in with the public relations program should be, and we are planning for this, an expanded hospital auxiliary. It should expand not only in number of activities but also in number of active chapters. We hope to establish several branches of the auxiliary in near-by towns. Those people can maintain their local identity and yet work on behalf of the hospital."

VOLUNTEER ACTIVITIES

No Real Drop-Outs

There has been no wasted effort in the training of men volunteers at Presbyterian Hospital, Chicago. Out of the first graduating class of 27 who went to work last June only two volunteer orderlies have dropped out. These two have left the city but expect to continue the service in some hospital in their new location. A second class of men volunteers started their training course last autumn. Twenty of these are employed by day at Wilson and Co., packers. This business organization supplied a large number of the first group, which included Edward F. Wilson, president of the company and a member of the hospital's board of managers.

"100 Men and a Girl"

Other enthusiastic volunteers in Chicago belong to the Men's Service at Michael Reese Hospital. This group expects to recruit new volunteers until it has a membership of 100. The plan is to have a group of 20 men for each week day evening from Monday through Friday. They will assist Mrs. Alta LaBelle, the housekeeping director.

Twenty-three men comprise the original group. They have recharged all the fire extinguishers in the hospital, taken blackout paint off the windows, washed light bulbs and cleaned fans, helped to keep soap dispensers filled, greased gatch beds and done other odd jobs for which paid workers cannot be found.

The men volunteers take their work seriously. The following note was received recently by their chairman.

"Please excuse Mr. Morton A. Livingston from work on Monday evening, February 26. He is going to be out of town and just can't come.

The Little Woman."

Laundry Room Rivalry

Those swing shift volunteers at the Evanston Hospital laundry, Evanston, Ill., keep production, spirits and rivalry high by means of a poundage chart. The husbands and wives who report for duty on Tuesday evenings may turn out 600 pounds so it is up to the school teachers on Thursday to equal or better that record. It is amazing what can be done by an enthusiastic small group in a three hour evening shift although oftentimes the volunteers work longer than three hours at a stretch.

These groups sort, stretch and pile linens so that they are ready to mangle. Operating the mangle itself is a job both the men and women seem to like. They are full of pride and excitement when they can keep up a good steady pace on the big machine.

There are daytime volunteers in this hospital laundry, too. They can hold up their heads with pride in competition with the evening workers.

Admission Price: One Book

The pretty Valentine party that the auxiliary of Norwegian-American Hospital, Chicago, gave on the appropriate date yielded several shelves of good books for the patients' library. A book was the price of admission.

At the annual spring party to be held April 21 guests will learn who among them won the war bonds and the needle-point chair. One of the auxiliary members made the needle point which adorns the chair. The proceeds will purchase new equipment for the nursery.

Wesley Trains Them Early

The Wesleyettes of Wichita have not yet reached their teens but they are proving a lively and an energetic group of volunteers. They had been active about the hospital for a year, running errands, folding papers for the dressing carts and making favors for special occasions but since their performance last Christmas they are no longer probationers but are recognized as bona fide auxiliary workers.

At that time 10 little girls volunteered to make and to decorate 300 tiny bedside Christmas trees so that each patient who could not walk or be rolled in to see the great tree might not feel neglected. When Christmas came the 300 little trees were ready; moreover the Wesleyettes had formed themselves into a glee club which sang carols around the big tree.

The youngsters get their name because they work for Wesley Hospital in Wichita, Kan.

Not a Postwar Project

Speaking of Wesley, we haven't mentioned the religious structure which is being planned for the hospital's west lawn. The women's auxiliary is financing it and the chances are good that its erection will not have to wait for the war's end inasmuch as removal of the present chapel from the space it now occupies in the hospital proper will make available badly needed bed space. Since Wesley is a cadet nurse training center, materials will no doubt be released by the War Production Board.

Why a Consultant

EVERETT W. JONES

MANY of us have shuddered as we have gone through hospitals so poorly designed and equipped that efficient use of personnel is impossible. Hospital trustees and administrators must awaken to the difficult technical problems involved in designing a new hospital or an addition to an old one, if the plant is to be capable of efficient operation. In the days to come, hospitals will pay fewer but better employes much higher wages than in the past. This will call for more efficient and adequately equipped plants that can be operated with fewer employe hours per patient.

In planning and developing efficient hospitals a qualified hospital consultant may add much of value to the work of a qualified hospital architect. Progressive and far-sighted industries and hospitals have long since discovered the value of outside consulting services in planning their physical plants. The less experienced the architect and the hospital administrator, the more there is need for a hospital consultant. Even the ablest administrators and hospital architects may benefit from broader contacts.

It Takes Time to Learn

He is a wise man or a fool who considers that he has mastered all the intricacies of nursing and medicine in a matter of weeks or months when the graduates of these professions spend from three to nine years in earning their diplomas. The capable hospital administrator also serves an apprenticeship, often of five years, in seeking to learn how to conduct a hospital so that doctors, nurses, dietitians and other specialists will coordinate smoothly their attempts to serve the patient.

The architect usually gets the information essential to his plans by repeated interviews with physicians and department heads. After he has been through this again and again he realizes the valuable time that he is obliged to expend. He recalls the headaches he endured in attempting to decide among the sometimes contradictory opinions and wishes of, for example, the pediatrician, the ophthalmologist, the orthopedist, the internist, the general surgeon, the obstetrician and the superintendent of nurses.

On the other hand, a consultant who as a hospital administrator has spent many years working with these specialists can discount their various hobbies, evaluate their phobias, appreciate their virtues and from the whole mass of advice vouchsafed judge what is significant and proceed to recommend something that will be acceptable to all concerned or will at least reduce future conflicts within the hospital. According to one architect, the greatest service a professional hospital consultant renders to the architect is in acting as a "buffer" between architect and hospital staff.

A reliable hospital consultant, with a background of years spent in hospital administration, can offer to the busy architect a well of information on technical questions relating to hospital procedures and requirements which the latter may tap at will. The average architect who plans only an occasional hospital cannot be familiar with such details.

Some architectural firms, of course, have designed so many hospitals and participated so intimately in this type of planning that they can be counted upon to do fine work without outside help. Even these might do a better job by working with a qualified consultant. Through his clarification to the architect of the functional results desired, the consultant can frequently save the hospital appreciable sums in the construction and equipment costs and, what is even more important, in later costs of operation and maintenance.

The day has passed for designing a beautiful building and cramming a hospital into it whether it fits or not. A hospital must be planned from within so that it represents the ideals of professional service in the minds of doctors and nurses and others engaged in the duties of caring for the sick. It must be planned so that it will conform to those multiple functional activities which, assembled together under a common roof and a unified administration, constitute the complex modern institution of healing, research, education and public health.

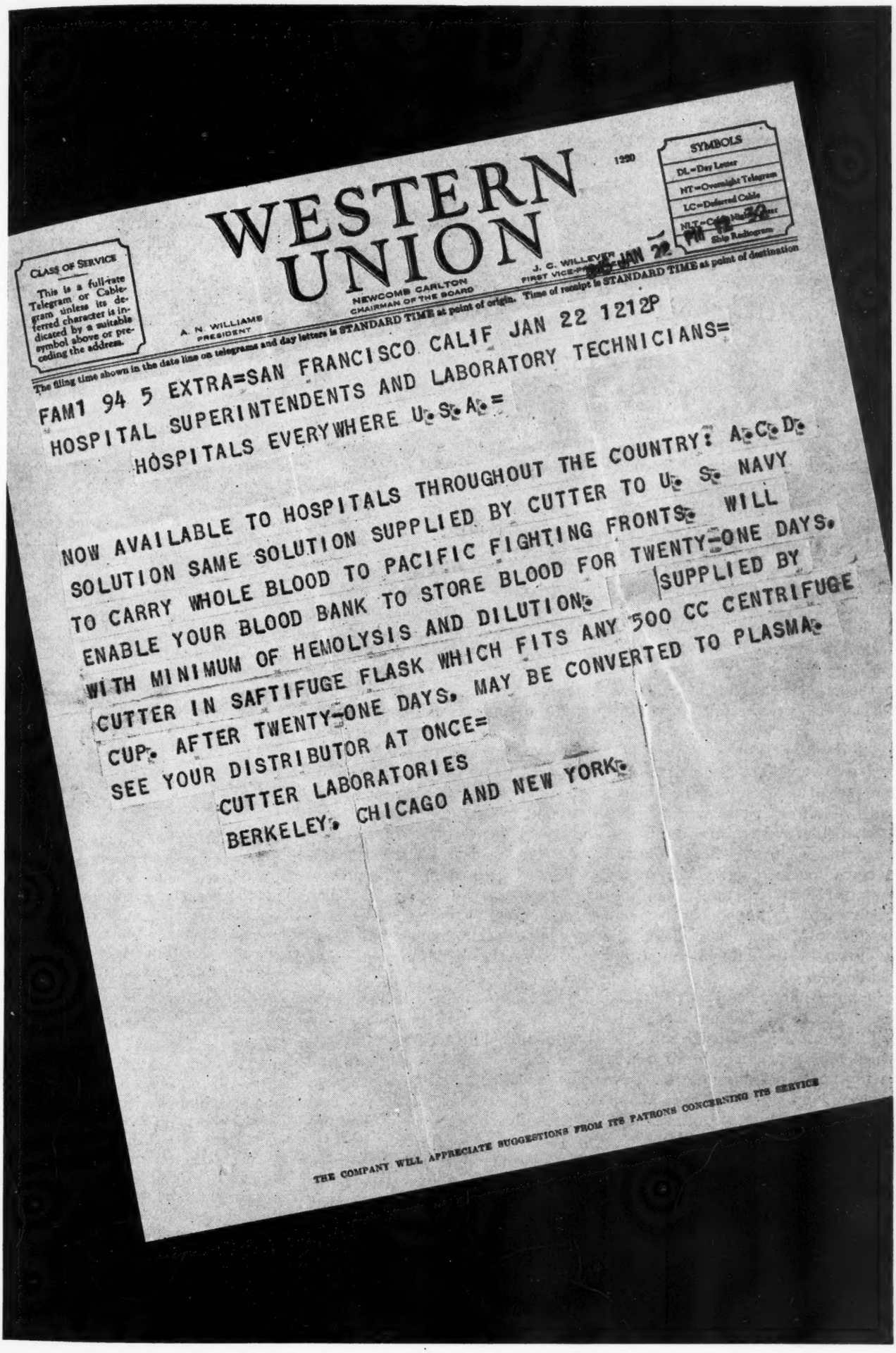
Consultant Speaks the Language

A hospital consultant who has spent years in actual hospital administrative practice can best comprehend the trials encountered by the hospital administrator whose hands must manipulate the strings that reach out to dozens of departments and to hundreds of individuals. He can speak the language of the pathologist, the radiologist, the physical therapist, the pharmacist, the interns and the medical staff. He can understand the complicated duties of the superintendent of nurses, the dietitian, the housekeeper, the laundryman, the engineer, the purchasing agent, the orderly. Most of all, he knows what the patient requires.

This encyclopedia of hospital information the architect may turn, page by page, as the hospital plans develop. Only those architects who have struggled with the planning of a modern hospital can evaluate the worth of such a reservoir of information at close hand.

Preparing the final working drawings for a hospital is a time-consuming task, including the planning of specialized departmental details and specially built-in cabinet details. Simultaneously with his meticulous development of the final working drawings the architect must prepare his specifications. At the same time the administrator should be compiling equipment lists. The assistance of the consultant in the preparation of these lists and his analytical study and comments upon them prior to their final acceptance can be of immeasurable value.

A capable architect, even without previous hospital experience, can



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build a fine hospital through collaboration with a qualified hospital consultant. Lack of such collaboration is one of the principal reasons why throughout the country there are hundreds of hospitals that can never be made to function smoothly and efficiently.

No competition need exist between consultant and architect. Preferably, each should work under a separate contract with the owner. The consultant represents practical operating and functional knowledge. The architect is the creative artist who captures the vision of improved service and places it upon paper, so that the contractor may, in turn, transmute it into stone and mortar and make it serve the sick.

Rehabilitation Is Essential

ALBERT LASKY

Montefiore Hospital Country Sanatorium
Bedford Hills, N. Y.

REHABILITATION, though variously defined, has become an important and timely subject. It is becoming a familiar topic in professional circles.

Hospital trustees will undoubtedly be giving increasing attention to the rehabilitation programs of their institutions.

Thirty years ago a young British doctor, the late Sir Pendrill Varrier-Jones, intrigued by the complexity of the problem, began to dream of the ultimate eradication of tuberculosis not merely by medical means but also by the assistance of psychology, sociology and economics. He was the great pioneer in the philosophy of the rehabilitation of the tuberculous. After his death in 1942, his secretary, Peter Fraser, gathered together and published in pamphlet form selections from his articles and correspondence under the title of "Papers of a Pioneer," published by the Hutchinson Press in London.

In pithy phrases, almost epigrammatic, the pages fashion the argument against the apathetic fumblings which have characterized the attack on tuberculosis. This little book is inspiring, if only for Varrier-Jones' steadfastness of purpose and his unfailing pursuit of a simple ideal.

The present method of antituberculosis control is "all middle and no ends." Sanatoriums are built to treat "early cases" that refuse to reveal themselves because of the nature of the onset of the disease and the lack of a routine for early diagnosis. Those who enter a sanatorium for a long period of treatment seem to lose their identity as people and become "cases."

After many months, and sometimes years, of hospitalization at an average cost of from $3000 to $4000 the patient is ready to be discharged. He cannot be told that he is cured, for the word "cure" cannot honestly be used with any finality in tuberculosis, and so the patient is told guardedly that his tuberculosis is "arrested."

When a tuberculous patient has to return to unfavorable conditions, a breakdown may be expected. In all honesty, therefore, the doctor will tell the patient upon discharge to get plenty of fresh air, good food, rest and a light job, with no idea how the patient will be able to do so. Although we have a fine nationally-organized case-finding and preventive program, we lack a rehabilitation program beginning *in the sanatorium* and culminating with scientific hardening, retraining and placement.

The failure to give rehabilitation and after-care for the tuberculous has made it difficult to capitalize on the many advances in diagnosis and active treatment. Our present knowledge still leaves about 50 per cent of the tuberculous unable to return to competitive employment and, at the same time, to stay well. Because of this fact, industrial village settlements, such as Papworth in England and sheltered workshops like Altro in the United States, are indispensable adjuncts to the hospital and sanatorium. Hospital trustees are in a position to make sure that they are provided.

Question of the Month

Each month in this column one question bearing upon hospital trusteeship is presented and answered. The editor is glad to receive questions which any hospital trustee may submit. All identification will be withheld. Replies will be made by mail pending their publication.

QUESTION: We are in process of making certain changes in our nursing committee and I should like to know what qualifications we should seek in individuals serving in such capacity. We have always restricted the membership to trustees but I am wondering if this is necessary or even wise. —L.F.R.

ANSWER: Qualifications for membership on the nursing school committee should be considered first. Whether or not the individual happens to be a trustee is of secondary importance. More than likely it will be necessary to go outside the hospital directorate to find those who are able to counsel wisely on this particular subject. An educator, that is a superintendent of schools, principal or teacher, should hold great potentialities. A representative of the church, one possessed of broad concepts of religion and faith, may have much to contribute. Someone with a background in social work should prove of help in considering recreational and home problems. These individuals will serve in addition to the nursing supervisor, one or two hospital trustees representing the policy-making group and, of course, the hospital superintendent.

It is not only advantageous but essential that the hospital draw from the community in coping with such specialized problems as nursing education. It is not within reason to find among a limited number of trustees those having knowledge in all lines. Furthermore, the presence of outsiders promotes community participation and interest and tends to broaden the base of support. No longer can hospitals be run by the few for the few. They must be controlled by the best interests in the community for the greatest benefit of the entire community.

The procedure recommended for the nursing school committee holds equally true of other groups. In every phase of its operation the hospital needs the best knowledge, brains and skill that the community has to offer.

Oxygen Therapy—I

The Administrator Considers Economy

WORTH L. HOWARD
Administrator
City Hospital, Akron, Ohio

ECONOMY in oxygen therapy requires the balancing of two broad considerations: first, the patient's requirements in terms of oxygen concentrations and methods of administration; second, the conservation of oxygen and equipment.

It is not the purpose of this article to discuss the medical indications of oxygen therapy or the methods of giving oxygen under varying clinical conditions. It looks at oxygen therapy through the eyes of the hospital administrator with two focal points in view: first, oxygen as a medicine and, second, oxygen therapy as an economic problem.

That's No Way to Prescribe

Oxygen therapy comes of age in each hospital the day that hospital recognizes the fact that oxygen is a medicine. Nearly every nurse who has handled an oxygen case will smile in recollection of an incident similar to the following: A patient is very ill, the worried physician straightens up with stethoscope still dangling from his ears and says to the room at large, "Let's give him oxygen." There ends the prescription.

We won't discuss the probable tardiness of the measure; the important fact is that there is no clear-cut prescription, probably no mention of the method of administration, much less an exact dosage in concentration or liter flow.

What would happen if this had been any other medication or form of therapy, for instance, the infusion of intravenous fluids? The nurse and hospital would expect a definite prescription as to the amount, method of administration and type.

Oxygen can and should be prescribed exactly. The hospital that does not demand this of its staff physician is assuming an unfair burden of responsibility which is loaded with impending difficulty.

If you put this article down and immediately write a memorandum to your staff to the effect that no more requests for oxygen therapy will be honored unless a clean-cut prescription is given to the attending nurse, it will be a right step forward. But, wait a minute! Don't put it on the bulletin board. You had better look to your end of the deal first.

Is your organization capable of carrying out this prescription properly? Do you have suitable equipment and do your nurses know how to go about reproducing the prescription? Will it be possible to give the 50 per cent, 70 per cent or any other specific concentration of oxygen with any reasonable assurance? It is not a difficult job with present day knowledge and equipment, but, unfortunately, the average hospital is not prepared to do it.

This article is not going to provide all details but it will give some good hints. The bibliography at the end of Miss Nickerson's article will provide sources of authoritative data; the literature of some of the oxygen equipment firms will prove helpful, and there are a number of hospitals that have created oxygen therapy departments that will gladly share their experience.

You will want to confirm and elaborate on the following: Oxygen dosage, as is true with any other medicine, should be prescribed and maintained in accordance with the clinical condition of the patient. There are some unfortunate and widespread misunderstandings in the matter of oxygen dosage: for instance, that a 50 per cent concentration of oxygen is desirable in all cases. This is as faulty as a standard procedure of giving ½ grain of morphine to all patients regardless of size, age, history and clinical condition.

As an indication of the value of oxygen under proper prescription, its use with a coronary thrombosis patient will be interesting. If oxygen is given in high concentrations, 95 plus per cent, by a mask, pain relief is likely to be dramatic and as effective as any morphine therapy. However, if an attempt is made to gain the same effect by giving 40 or 50 per cent oxygen by tent or catheter the results will probably be disappointing.

Another of the great misconceptions in oxygen therapy concerns the amount of oxygen necessary to produce a given concentration. Hundreds of instances have been observed where nasal catheters have been operating at oxygen flows of ½, 2 or 3 liters a minute. Such rates of flow are considered inadequate to produce really therapeutic dosage with adult patients. Face masks will be found operating at 1 or 1½ liters a minute on adults and again the patient is probably receiving little oxygen therapy.

Oxygen Analyses Too Rare

The greatest mistakes occur in the operation of oxygen tents. It is only the rare hospital that makes routine oxygen analyses of the tent atmospheres. The analyzer can be compared to the recording instruments on an x-ray machine. It provides the only means of determining performance of the equipment. The importance of routine analysis cannot be overstressed.

The average tent in this country is properly operated with an oxygen inflow of 6 liters a minute or less. If questioned, the physician would think that his patient was getting 50 per cent oxygen concentration; he is probably not getting 30 per cent and there is, of course, 21 per

cent oxygen available in room air which means that the amount of therapy is negligible. To satisfy yourself on this point obtain an oxygen analyzer and the next time a tent is operated in your hospital have a series of analyses made at frequent intervals. The results should be interesting.

But, you say, this is information that should be in the hands of the doctor. True, but it is more important that it be in the administrator's hands as oxygen therapy is a mechanical and nursing procedure from start to finish. The hospital administrator must first be aware of the conditions before a start can be made toward producing effective and economical oxygen therapy.

One vital reason for reviewing these facts is to eradicate from your mind the possibility of taking the apparently natural step toward economy in oxygen therapy, that is, the reduction of oxygen flows to the patient. On the contrary, the average hospital should increase the amount of oxygen delivered to every patient by at least 50 per cent in order to produce anything like desirable clinical results. If this seems contrary to your thinking in terms of economy, recall how much oxygen therapy has probably been given in your hospital that has been a total waste.

Thus, the first step to take in solidifying the oxygen therapy program, so that the memorandum which you have written can be safely posted on the staff bulletin board, is a basic knowledge of the mechanics of giving oxygen. Every existing procedure should be carefully analyzed in the light of accepted present day information. It may be necessary to add somewhat to your equipment inventory, but probably not. The latest types of oxygen equipment, the new face masks and nasal catheter units are relatively inexpensive and a small expenditure at most will probably bring you well up to date.

Now you are prepared to handle the medical requirements of oxygen therapy but what about the mechanical and economical phases.

The mechanical and economical failures of oxygen therapy revolve around a multitude of technical details: the return of residual oxygen in supposedly empty cylinders, poor storage facilities for cylinders and equipment, careless management of cylinder movements around the hospital, leaking regulators and fundamentally poor nursing procedure. To these can be added such items as careless systems of reporting charges and lack of any separate balance sheet on the cost and income of oxygen therapy.

As long as all of these factors are not consolidated and are at the mercy of practically every employe in the hospital one can never hope to attain a fundamentally sound situation regarding the administration of inhalation therapy. Over a period of many years it has been conclusively learned that the whole complement of nurses and orderlies in any specific hospital can never be taught to handle properly all the details involved in giving oxygen to the patient. It is obvious, therefore, that the success of oxygen therapy depends on centralized control.

Most hospitals, regardless of size, could adopt the following basic plan: Appoint a member of the medical staff to have charge of inhalation therapy. Then, assign the job of doing the work to one department

or individual. The anesthesia department is probably best fitted to assume this activity.

The ideal setup for the large hospital, where inhalation therapy is extensive, is to have a doctor supervise the entire activity, the anesthesia department to have responsibility for all practical phases and a specially assigned individual to do the work. (If your anesthesia department is headed by a physician it should not be necessary to appoint another doctor.) When this activity is not large enough to support such an organization, drop the technician and assign the technical work to one or two capable nurses or orderlies.

Under any conditions make a clear-cut assignment for the responsibility of oxygen therapy and perpetuate it in the event of personnel changes. This form of therapy is expanding rapidly and shortly will incorporate a sizable amount of work and considerable expense in every general hospital. The inhalation therapy activity can be made to be self-supporting.

The medical supervisor in the plan outlined should have the following responsibilities:

1. To examine every oxygen case regularly to check on technics and procedures.
2. To set up suitable forms for recording clinical data and arrange to have this information properly entered by attending nurses or technicians.
3. To set up suitable forms for maintaining a continuous record of oxygen treatment to indicate the amount and cost of materials used.
4. To provide adequate training for those who will handle the actual administration of the therapy.
5. To arrange for teaching inhalation therapy to the entire complement of nurses and orderlies as well as interns.
6. To keep abreast of advances in the therapy from the clinical and technical points of view. This will include being familiar with all equipment developments and technics.

The following duties should be assigned to the department or person handling the practical phases of oxygen administration:

1. To set up and operate suitable systems for ordering, storing and dispensing all supplies and equipment.
2. To set up and operate all types of inhalation apparatus. This will necessitate routine visits to every oxygen patient every day at which time a thorough checkup should be made. If tents are used, analyses of the tent atmosphere should be made and the results recorded on the patient's chart.
3. To arrange for the cleaning, sterilizing and repair of all equipment.
4. To set up and maintain a system for making charges.
5. To maintain records to show all data pertaining to the cost and income of oxygen therapy.

There are many individual points of procedure that can be adopted in the interest of economy and efficiency. However, the act of assigning responsibility for inhalation therapy will prove the greatest single thing that can be done to effect a sound economical handling of this therapy. Furthermore, with the inauguration of a well-organized department you and your medical staff will be pleasantly surprised with the often dramatic results obtained with a treatment which has frequently seemed of questionable value.

Oxygen Therapy—II

The Therapist Talks of Technic

IRMA W. NICKERSON, R.N.
Assistant Director of Nursing, City Hospital, Akron, Ohio

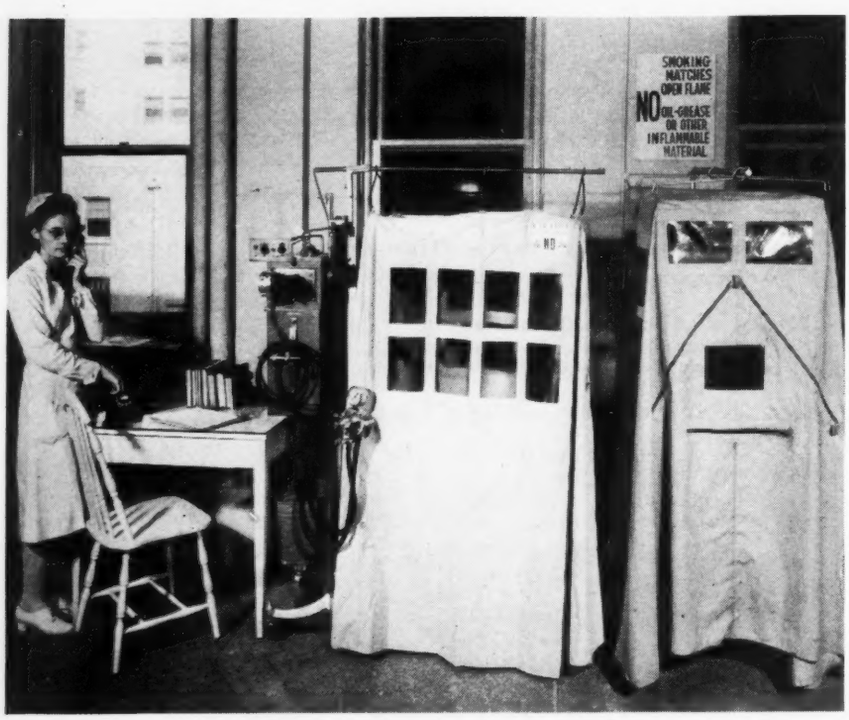
BECAUSE of the place that oxygen now holds as a remedial agent, the hospital must develop a method of handling equipment that will make its administration for therapeutic purposes as effective as possible.

Many administrators have foreseen the danger of entrusting the administration of oxygen to untrained personnel and are employing oxygen therapists to deliver effective, economical and suitable treatment to the patient.

In spite of the difficulties under which all hospitals are functioning, it is still excellent economy to appoint a registered nurse to fill the position of oxygen therapist to supervise the administration of oxygen and use of equipment. This seems justifiable because the nurse is acquainted with the principles underlying nursing procedures, has a basic knowledge of anatomy and physiology, is familiar with the specific technics used in treatment of diseases and has assisted with emergencies for which oxygen therapy is frequently prescribed by the physician. The aim here is to outline a procedure that has been found to function very satisfactorily.

Equipment Necessary for Oxygen Department of a 500 Bed Hospital

EQUIPMENT	QUANTITY
Oxygen tents	10
Canopies	12
Gauges (2 stage)	16
Nasal catheters No. 10	16
S.O.S. humidifiers	8
Bells with handle	10
Room thermometers for tents	10
Straps for cylinders	12
Cylinder carriers	4
Rubber tubing No. 6 (allow 4 inches for each set of nasal O_2)	
Glass irrigation tips	12
Masks:	
Oro-nasal O.E.M. meter masks	2
Nasal O.E.M. meter masks	2
Oro-nasal B.L.B. masks	2
Nasal B.L.B. masks	2
Oxygen analyzer	1
Liter floor test gauge	1
Wrenches (small)	1
Wrenches (adjustable)	2
Hard rubber grippers	18
Safety signs	24
Cylinder content tags	500
Racks for canopies	3
Two cylinder manifold	1
Adaptors to connect commercial regulators to medical tanks	2
Yoke to medical adaptors (for "D" tanks oxygen for nurseries)	8
Funnels	8



Canopies are hung on racks which prevents the rubber from sticking.

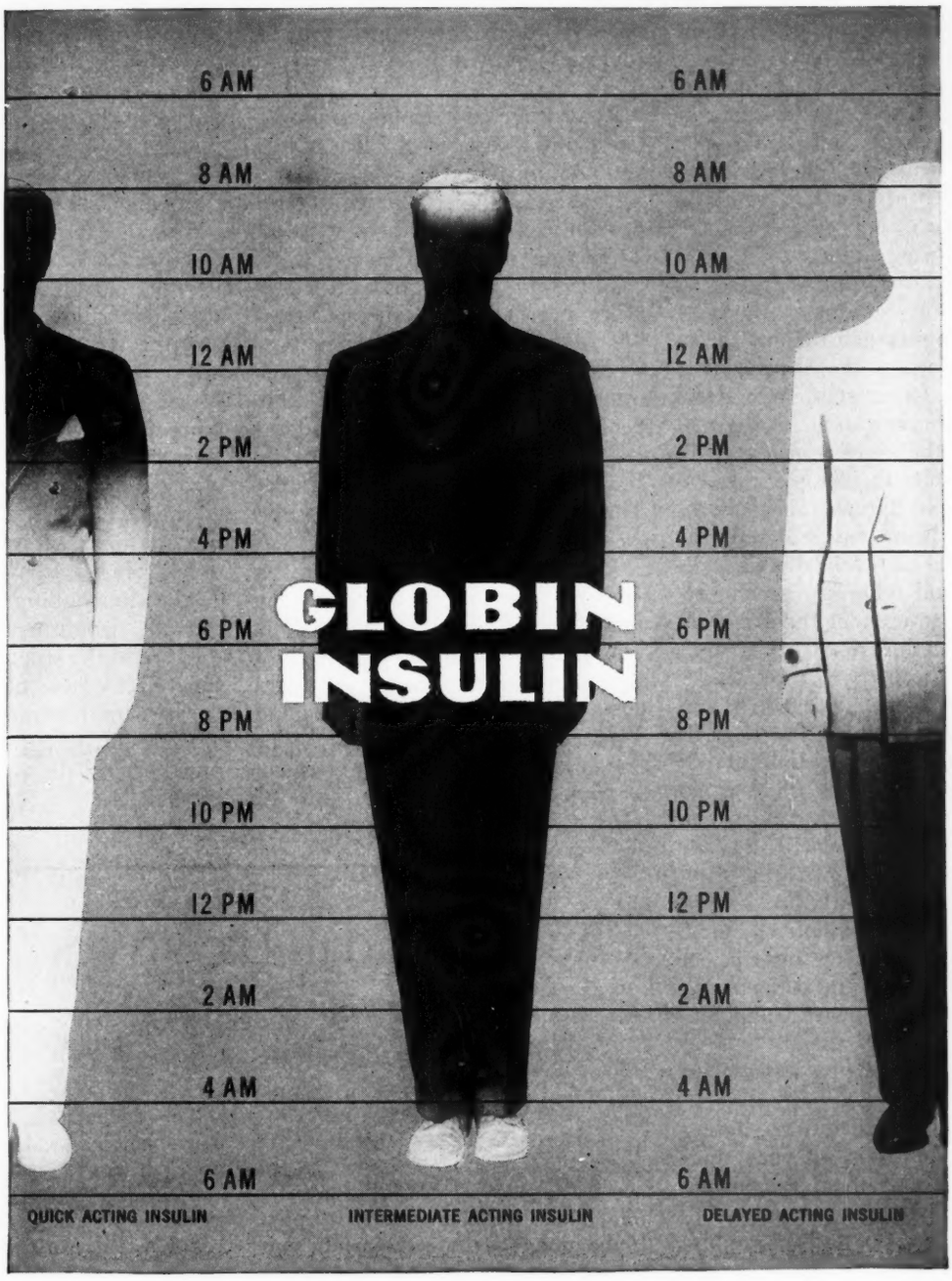
Equipment Is Delicate

Many hospitals give oxygen therapy service but, unfortunately, entrust service and equipment to untrained personnel and improper supervision. Most oxygen equipment is of fairly delicate construction and should be handled by as few persons as possible and only by those who are specially trained for this service.

Space was provided in our hospital for the storage of oxygen and equipment. In a room set aside for the purpose a bathtub was installed on a platform so that the therapist could work more easily while washing canopies and other equipment. Racks were made in order to hang the canopies so they would not have to be folded together; this prevents rubber from sticking together and saves the windows in canopies from cracking. A shelf was provided with grooves for each gauge to prevent the gauges from falling or knocking together as they are delicately constructed and should be handled and stored with great care.

A cabinet was installed for storing humidifiers, masks, catheters, rubber tubing, straps for cylinders, the oxygen analyzer and cleaning materials. Signs were posted over cylinders in order to distinguish full and partly full cylinders of oxygen and carbon dioxide. A desk for

At Akron City Hospital, Akron, Ohio, the therapist has four orderlies to cover oxygen therapy for the twenty-four hour interval, one for each eight hour shift and one relief orderly to cover for days off. The orderlies are thoroughly trained in this field in order to handle oxygen equipment in the proper manner and they are most helpful to the therapist in delivering oxygen equipment and cylinders to the units where therapy is prescribed.



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Many moderately severe and severe cases of diabetes may be controlled with only a single, daily injection of 'Wellcome' Globin Insulin with Zinc. This new long acting insulin is a clear solution of uniform potency. In its freedom from allergenic skin reaction, it is comparable to regular insulin. This advance in diabetic control was developed in the Wellcome Research Laboratories, Tuckahoe, N. Y. U. S. Patent 2,161,198.

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necessary records and a telephone are provided.

New reference material for students, general staff nurses and the therapist is kept in the oxygen room.* In this way the personnel has available information regarding new methods of oxygen therapy and new equipment.

The oxygen therapist assembles the equipment for various methods of administering oxygen therapy to patients; she charts the thermometer reading in each oxygen tent, and she tests the concentration of oxygen tents with the oxygen analyzer to ensure an efficient therapy. At two hour intervals, the therapist checks the oxygen being administered; she changes nasal catheters, detects leaks in gauges and other equipment, replaces noisy equipment and examines all oxygen cylinders to see if they are strapped securely to the bed.

It is the responsibility of the therapist to be aware of all fire hazards when oxygen is being administered; she must be sure that there is no smoking and she checks all oxygen tents to see that the patients have bells rather than signal cords. Electric signal cords are a fire hazard because they may be short circuited. This supervision makes for efficient therapy and imbues the patient with confidence in the service being rendered.

The oxygen therapist serves as a teacher and supervisor for all general staff and student nurses, aiding them in administering oxygen therapy and teaching them the proper technic in handling equipment.

The therapist not only assembles the equipment but when oxygen therapy treatment is discontinued checks used equipment and notifies the maintenance department if any repair is needed. She cleans all the equipment after the therapy is discontinued, washes and autoclaves catheters, sterilizes rubber tubing, airs the oxygen tents on the roof for one hour and then washes the canopies thoroughly, hanging them on the racks provided in the oxygen room to dry.

Records are another important factor in the assurance of efficient oxygen administration.

Oxygen cylinder "content tags" have proved to be highly economical. These tags are placed on every full cylinder of oxygen. When the cylinder is turned on, the therapist tears off the first level of the tag marked "full." After the treatment is discontinued, the amount left in the cylinder is recorded on the tag and the tank is returned to the oxygen room and placed with the partly full tanks. The same process is repeated until the cylinder is empty.

A "caution tag" is also hung on the tank which serves as a recording agent for the oxygen concentration.

A form for oxygen requisition is sent from the oxygen supply room when the treatment is prescribed and is placed on the patient's chart. The therapist records the date treatment is started, time, cylinder number, pressure and the amount of gas in the cylinder. When treatment is discontinued, the therapist totals the amount of oxygen consumed and sends the form to the cashier's office for billing.

Another important and useful record is the "eight hour check." On this form the therapist keeps a full record of all the equipment being used, recording the room number and the unit in which oxygen therapy is being administered. A copy of this record is kept in the nursing office and in the oxygen room. This form is highly important as it gives a complete picture of the location of equipment in use so that, in case of fire, the oxygen can be discontinued quickly.

The functioning of our oxygen therapy department has simplified the care of the sick and has increased the effectiveness of treatment; the department has rapidly grown into an efficient, integral part of a hospital serving the people of its community.

***Reading List in Oxygen Room**

Barach, Alvan L., M.D.: Principles and Practices of Inhalation Therapy. Philadelphia: J. B. Lippincott, 1944.

Andrews, Albert H., Jr., M.D.: Manual of Oxygen Therapy Technique. Chicago: Year Book Publishers, Inc., 1943.

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The Colloidal Laxatives

A. J. LEHMAN

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ONE of the ills that frequently besets the human race is constipation. This is a condition which the layman feels competent to treat for himself and he is, therefore, receptive to the numerous advertisements publicizing laxatives. He has been repeatedly assured that intestinal bulk is about all that is needed to correct faulty elimination. As a result, self-medication with the bulk or colloidal laxatives has become an almost daily habit for many individuals. Despite numerous attempts, the status of the efficiency of these agents has not yet been satisfactorily established. Some of the most recent information on the subject is given below.

Colloidal laxatives are gummy substances which possess the quality of swelling when placed in water so that their bulk may be increased by fifty-fold and more. These agents are not affected by the digestive enzymes and are not especially influenced in their hydrophylic properties by the presence of dilute acid and salts in concentrations existing in the gastro-intestinal tract.

The colloidal laxatives are principally plant gums, hemicellulose in nature, although certain colloidal clays and cellulose derivatives have been suggested as possible substitutes. For convenience the various agents may be classified as follows:

Plant Gums.

1. *Acacia.* This is known as gum arabic or gum acacia and is one of the oldest commercial products. It is derived from the acacia tree as an exudate. The water-soluble fraction consists of gum arabin which is composed of pentose and hexose sugars in combination with uronic acids.

2. *Agar Agar.* This is a substance derived from sea kelp and is capable of taking up considerable quantities of water. Agar has found extensive use in pharmacy as an emulsifying agent for liquid petrolatum (mineral oil). Sodium alginate, also obtained from kelp by processing with acids and alkalies, has not been employed as a laxative.

3. *Tragacanth.* This gum is a close relative of acacia and is also a plant exudate. The soluble portion of the gum is not identical with arabin al-

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SUSTAINED VASOPRESSOR EFFECT... marked rise in blood pressure lasts fifteen to thirty minutes or longer.

UNDIMINISHED effectiveness even after repeated administration.

FREEDOM from cardiac stimulation and nervous excitation. Often useful where other pressor agents are contraindicated . . . Neo-Synephrine is a pressor drug of choice during combined continuous spinal and cyclopropane anesthesia.*

*Rochberg, S.: *Anesth. & Analg.* 22:174, 1943.

INDICATED in prevention and treatment of circulatory depression, especially in shock-like states, during spinal or inhalation anesthesia.

DOSAGE: Average subcutaneous or intramuscular dose is 0.3–0.5 cc.

FURTHER FACTS AND SAMPLES WILL BE GLADLY SENT ON REQUEST

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though some of the properties are similar. The insoluble portion is called bassorin which has the property of swelling in water to a considerable bulk. Other tragacanth products which have obtained commercial importance are bassora and karaya gums. The former is obtained from Persia and is of unknown derivation and the latter is a product that originates in India. Both substances swell considerably without disintegration when placed in water and thereby differ in this respect from acacia.

The caramania gums are a third class of plant products which have bassorin as their principal constituent. These substances do not swell in water to the same extent as does tragacanth and do not form gelatinous masses because they consist of independent granules which are not cohesive. This property could be a valuable attribute in the light of therapeutic application.

4. *Psyllium*. Psyllium or Plantago seeds have been used for hundreds of years. Three sources are recognized by the National Formulary, namely, black, Spanish or French and Indian. A number of commercial products are derived from these and other varieties of psyllium seed.

Colloidal Clays.

1. *Bentonite Clay*. This has the property of swelling when placed in water to form a gel-like mass. It has not yet found its way into commerce as a colloidal laxative.

Cellulose.

1. *Methyl Cellulose*. Some attention has been given to this material as a substitute for vegetable gums laxatives. The compound will dissolve slowly in water to produce a thick gel.

Hydrophilic Properties

The ability of the various products to absorb and hold water has been measured *in vitro* by placing a weighed amount of the substance in a suitably graduated vessel and adding water or dilute solutions of hydrochloric acid, sodium bicarbonate and sodium chloride to simulate conditions in the gastro-intestinal tract. Under these conditions the tragacanth derivatives showed the greatest increase in volume, averaging about 20 times the original.

Acacia and the clays showed the least changes and this may account for the lack of interest in these agents for use as laxatives. Psyllium as the whole seed swelled only about five times the volume of the dry seed. However, the ground seed showed a ten-fold increase as an average.

The effects of mechanical agitation on the colloidal gels seem to emphasize that these gummy materials form a fairly stable mass. This indicates that intestinal peristalsis has little influence on the colloidality once the gel is formed.

Clinical Evaluation

The efficacy of the various colloidal agents in the rôle of a laxative has been tested clinically. The accompanying table is a summary of several tables of data by Gray and Tainter, which appeared in the *American Journal of Digestive Disease* (**8:** 130, 1941) and by Tainter in the *Proceedings of the Society of Experimental Biology and Medicine* (**54:** 77, 1943).

Among the criteria set down as a measure of the usefulness of the agents listed were the daily fresh weight, consistency and frequency of the stools. These were compared with control values. The dosage was 5 grams of the substance under investigation daily with the exception of methyl cellulose; this was administered in 5 gram doses twice a day. According to the data psyllium seed swelled to five times its volume in 2 per cent salt, a physiologic concentration in the bowel, and increased the fresh weight of the stools by 22 grams. Water content was actually 2.1 per cent less than the control col-

A Comparison of the Laxative Action of the Colloidal Drugs

Classification	Product*	Hydrophilic Properties: Volume Increase in 2 Sodium Chloride	Influence on Stools—Change From Control: Fresh Weight (grams)	Water Content (per cent)	Dry Weight (grams)	Number
Psyllium	Psyllium Seed	5 times	+22	−2.11	+5.8	None
	Mucilose	10 times	+16	+3.74	−4.7	"
	Konsyl	11 times	+26	+2.71	+2.5	"
	Siblin	5 times	+ 9	+4.16	−3.5	"
Tragacanth	Karaya	18 times	+15	+1.14	+2.3	"
	Imbicoll	24 times	+51	+2.90	+8.5	"
Cellulose	Methyl Cellulose	40 times	+104.7	+1.20	+16.9	Slight increase

*The dosage was 5 grams a day for all agents with the exception of methyl cellulose, which was given in 5 gram doses twice daily.

lections. Constipation was noted as a side effect and is in keeping with the water loss. Dry weight of the feces was increased by about the amount of the seeds ingested.

The three processed derivatives of psyllium, mucilose, konsyl and siblin, not only increased the fresh weight of the stools but also added to the water content by 3 to 4 per cent. The dry weight values indicate that two of the products are partly destroyed by enzyme action and that the laxative action is partly colloidal and partly irritant.

The tragacanth derivatives, karaya and imbicoll, appear to possess a greater laxative action insofar as the fresh weight of the stools is concerned, but further analysis of the values indicates that their ability to hold water in the intestinal tract is not commensurate with their hydrophilic properties.

The anomalous product of the entire group appears to be methyl cellulose. It swells markedly in salt solution. The administration of this substance increased the feces weight by about twice that of the control. Dry weight was increased by 16.9 grams or 6.9 grams over the predictable 10 grams, the dose of methyl cellulose ingested. This, of course, illustrates the difficulties encountered in evaluating laxatives. It can be stated that an extensive study of methyl cellulose to be published soon by Bauer of Wayne University indicates that the synthetic cellulose derivative is a poor laxative and has a tendency to be obstipating. This is not in line with the data presented in the table.

All of the clinical studies summarized in the table were performed on healthy young adults. The laxative action was not very marked. It is possible that laxatives effects of the colloids in elderly individuals with sedentary habits and prolonged bowel dysfunction might be even less favorable. At least the various studies up to the present have not shown any clear-cut correlations between the hydrophilic properties of the gums and their laxative action.

Let PSYCHOLOGY Help

In breaking down the patient's resistance to those foods he needs but doesn't want or those he wants — but should not have

MARY ANNA S. FERRARO
Director of Dietary Department
St. Vincent's Hospital, New York City

HOSPITAL administrators and physicians have a tendency to place the responsibility for the proper feeding of patients on the dietitian without considering a number of important aspects.

It is quite true that the dietitian is in a position to translate the doctor's prescription into a series of well-balanced and palatable meals for the patient for whom the diet is prescribed. It is also true that the hospital administrator has the right to expect the dietitian to present properly planned and palatable meals to the patients for whom no special diet is prescribed. By and large, however, hospital dietitians have a tendency to fall into a rather stereotyped scheme of things. Even dietitians whose superintendents boast about their efficiency and good work do the thing in terms of mass feeding rather than feeding individuals.

There are many reasons for this. One is that a well-prepared meal with a few choices is usually accepted through the whole institution and, second, too many varieties raise the food cost. Even bearing in mind the necessity for feeding large numbers of people and the fact that food costs must be kept to a minimum, it is still quite possible to use psychology in proper feeding.

What It Does—Not What It Is

A diet must be evaluated by what it does rather than by what it is. No matter how well it is balanced from the nutritional standpoint or how well it follows the prescription of the physician, a meal is of no value unless eaten in its entirety by the patient. It may be well planned scientifically, and most diets today are carefully calculated, but on many of the patients' trays the food has not been consumed completely. This is an indictment against the dietitian's ability to apply scientific psychology to her problem.

The food is rejected for several reasons, chief of which are lack of appeal, monotony, untidy trays and disregard of the patient's likes and dislikes. Even if the food sent to the patient has been varied, even if the trays look as though they have been prepared to be used in a women's magazine as a model of a tasteful and attractive meal, there are still many patients, especially those who have dietary deficiencies, who will still be resistive to diet.

Emotional Conflicts Arise

It must not be forgotten that the psychological reactions of the patient who is hospitalized are worthy of a great deal of attention and too often they are overlooked. The patient is in an unnatural setting, has been treated in a way that is seldom pleasant. His life is relatively monotonous and the only way that he can express himself is through his reaction toward food. All of the pent-up objections which he has accumulated during his stay in the hospital come to the surface at the sight of his tray.

For most of us food is associated to a large extent with things pleasant, such as memories of home, mother's cooking and the Class Dinner. When it becomes part of medical treatment, such as a special diet, and there is restriction on articles of food that are enjoyed, or when unaccustomed foods are added, conflict arises. Even though the tray represents the best in balanced fare for food elements, minerals and vitamins, if the patient is psychologically unwilling to eat, it behooves the dietitian to utilize psychological aids.

Psychology Not Recognized

Psychological factors involved in the management of the patient on a diet have been too seldom recognized. The dietitians who are concerned with food clinics, particularly those who are trained by Frances Stern at the Boston Dispensary, realize the importance of gaining a great deal of knowledge about the patient. Dietitians in a clinic devoted to furnishing proper nutrition to problem patients take a full case history, quite as full as that of the physician, but designed primarily to gain information about the feeding habits and the likes and dislikes of the patient. Sometimes this information is so complicated, as when, for instance, food has been rejected because it is a favorite of a hated father, that the assistance of the clinic psychiatrist is necessary for proper evaluation.

Sometimes the patients are found resistive to certain parts of the diet

because the food prescribed is contrary to what they have been brought up to enjoy. Corn, spaghetti and rice are three forms of carbohydrate calculated into a diabetic diet; the spaghetti is preferred by the patient of Italian background and rice would be selected by a Chinese patient. The converse of this would cause dislike. While these are easy adjustments to make, they mean much in obtaining the patient's cooperation with the diet.

Association of particular articles of food may be traced back in many instances to happenings in childhood. One patient confessed to his dislike for sea food because of its association with a tyrannical aunt who seemed to enjoy fish with an obsessed delight. He could never smell it in later life without distaste, for it represented her to him. It took much psychology and artful handling before Mr. B would taste fish. However, gradually the article of food was brought back to acceptance and its association with his aunt was broken.

The comparison of the reactions of two overweight patients to acceptance of a low calorie routine shows the importance of the psychological adjustment of the patient.

'Twixt Love and Diet

Miss P. M., aged 29, weighed 242 pounds and was exceedingly uncooperative about following the reducing diet. Upon careful inquiry it was learned that her fiancé was pleased with her size and that she was torn between losing him and carrying out the doctor's order to reduce.

It was decided that if she would make an effort to lose 42 pounds it would please the doctor and show him and the dietitian that she was trying and that, certainly, the fiancé would not disapprove. With this plan the patient was quite cooperative. Each week showed some loss, but the day she was last seen in the clinic her weight was 198 pounds and she refused to continue with the diet. No amount of persuasion could sway her from her belief that if she lost more she would lose her fiancé. There was a barrier set up which was impossible to destroy because of the will of the patient.

Mrs. C. D., on the other hand, weighed 238 pounds when she was first seen by the dietitian. She had been married and widowed twice, and in conference she disclosed the fact that she would like to be married again. Using this information as an impetus and to stimulate her will, the dietitian was able to show graphically that the patient lost 40 pounds in three months. This continued until nearly normal weight was attained, but never once did the patient say she wanted to go off the diet.

Psychologically these two cases offer comparison. The latter patient was cooperative because of her will to lose, the objective in mind, while the former patient lacked the will after a certain point was reached.

The use of the psychological approach is extremely important in the feeding of children in the hospital. A child who is away from home for the first time and is surrounded by strange faces is reluctant to eat, at least, at first. Many times, however, parents are amazed at the improvement in the child's eating habits while in the hospital. A difficult child to feed under ordinary circumstances often eats well when he is placed in a group. The child in a single room is more of a feeding problem than one on a ward who sees other children eating and, in order to maintain himself as a member of the group, imitates them.

In the case of the sick child it is important to bring to him as much food as he has previously enjoyed and not to introduce new articles of diet at this time or those which he has recently rejected. It is likely that revulsion against that article of food may establish itself firmly in the child's mind and become difficult to abolish later.

Those of us who manage hospital food as a means of therapy must be aware that there is more to the patient than his appetite to be considered. No eye appeal or captivating odors of the tray will overcome the mental rejection of a difficult patient. The use of psychology is invaluable for the hospital dietitian and is the answer many times to the query, "Why can't I get that patient to eat?"

We admit that all of the various factors cannot be discussed in detail here,* but we are able to suggest these few rules:

1. The standard tray for each meal should be considered not only from the standpoint of balanced nutrition and stimulating appearance but also from the standpoint of the food habits of the majority of the persons in the hospital.
2. Special diets should be based upon the likes and dislikes, as well as the food habits, of the individual patient and the dietitian, whenever possible, should have a complete list of these to be used during the whole time that the patient is in the hospital, rather than querying him before each meal.
3. In discussing the diet with the patient a minimum of attention should be paid to the physical ailment. If the patient wishes to discuss why he is restricted, that is his privilege, but for the dietitian to emphasize the restrictions at this time, or any time in the future, only adds to the patient's worry and burden.
4. The diet should never be discussed before a third person. The patient may take advantage of that situation in order to become querulous and difficult.
5. Testiness and irritability on the part of the dietitian or her assistants are never excusable. The patient may complain of the food when it is some other problem far removed from the food which is causing the complaints.
6. The time of feeding a patient should conform to the routine of the patient when he is at home so far as hospital facilities permit. The tendency to give breakfast trays at 6 or 6:30 a.m. when the patients are used to eating at 7:30 or 8 a.m. is disturbing and the gradual disappearance of this custom is to be commended.

Special Approach for Children

7. The approach to children should be positive rather than negative; emphasis should be on giving the little patient what he would like to eat rather than on encouraging him in his dislikes. A period of illness in a hospital is not the time for training children in correct eating except in diabetic cases and even there much understanding and tact must be used. The child who does not eat will be encouraged more often by being put with other children who do eat without discussion than he will be if too much attention is paid to him by his nurses.

*Selling, Lowell S., and Ferraro, Mary Anna S.: The Psychology of Diet and Nutrition. New York City: W. W. Norton Company, 1945.

London's Invalid Kitchens

Contribute to the Community Welfare

PHYLLIS LOVELL

Well known in Britain as a contributor to many magazines, especially on women's and social service topics. She is an expert writer on food topics and has published several cookery books

IMPORTANT postwar developments in the home treatment of invalids may result from the wartime experience and expansion of London's invalid kitchen organization, a movement first started in a small way 30 years ago.

The provision of a correct dietary for invalids was never an easy task for the ordinary household. In wartime Britain, food rationing, scarcities and the fact that all members of the family, often including the housewife, are engaged in full-time war work increased the difficulties. The problem has not been fully met, but the invalid kitchens, which cater exclusively to those requiring an exact and rigid diet, have spread to a number of boroughs. At present, they provide for people with very small means, but there would seem to be scope for their development throughout the country and among the higher income classes.

Meals Delivered if Necessary

The patients come regularly to the kitchens six days a week; in some cases, a dinner is prepared and taken to them on Sundays also. For bedridden patients and for those who are not well enough to leave home these ready-cooked meals are delivered by a fleet of cars fitted with vacuum containers to hold the dinner boxes. Four of these cars were donated by the British War Relief Society of America, which has also assisted financially in the foundation of the two most recent kitchens in the Poplar and Acton districts.

Every invalid kitchen is in the charge of a secretary, who is trained in dietetics and who supervises the cooking of meals. Each meal is prepared individually, according to the special needs of the patient. Diet sheets, set out by a hospital, clinic or a doctor, are consulted and exact quantities are weighed. This applies particularly to the meals for diabetic and gastric cases. They are built up on calorie values, within the limitations of foods which are both allowed in the dietary and are available. To meet the second need, many interesting improvisations have been introduced.

The gastric cases are usually covered by one of the four bland diets or by a combination of two of them, with a calorie value of 2826 calories a day. Vegetable purée, mashed potato, junket and toast, which are part of the diet, can be obtained easily. For the recommended meats, such as chicken, tripe, brains, sweetbreads and the fresh white fish and soft roes, it is usually necessary to substitute minced beef, mutton or rabbit. Fish is used when it is on the market. The juice of fresh oranges is replaced by black currant purée, and egg custard, by cereal pudding.

Here is a meal which I saw served to a gastric patient:

A small quantity of minced rabbit, with one mashed potato and spinach purée. Over this was sprinkled a proprietary food made from the embryo of cereals and containing vitamins A, B and E. For pudding, a junket was served with a spoonful of black currant purée. A thin slice of buttered toast accompanied the meal.

In the diabetic cases, the diet sheets are even more individual. Some doctors draw up actual menus, followed in exact detail by the kitchen's staff. Others divide the carbohydrates into groups as follows: (1) green vegetables and fruits containing less sugar; (2) root vegetables and sweeter fruits; (3) bread, biscuits, oatmeal, potato and jam. Those foods in the first two groups which the patient may take are underlined with the addition of so many portions of group 3. These diets, unless the doctor has ordered otherwise, are built up by meat, fish and vegetables to a calorie value of 2000 a day.

It's Hard to Vary Meals

Here again the variety is limited. Liver, ham, kidney and, at times, fish are scarce in Britain; beef, mutton and the ubiquitous rabbit more often take their place. Scarlet runners (green beans), tomatoes and onions, except for certain short periods of the year, are not obtainable and cabbage, spinach and cauliflower are used for bulk value.

This need for bulk is one of the more difficult problems for Britain's diabetics. Fruit, one of the prewar stand-bys, is imported by Britain in very small quantities, citrus fruits, especially, appearing only once or twice a year. Home-grown fruits are, of course, only seasonal and the supply is not great. So, while these and home-grown tomatoes are on the market, the kitchens buy up and bottle as much as possible for the feeding of diabetics during the winter months.

Here is a meal I saw served to a diabetic case:

The first course was a small piece of beef, divided into lean and fat, which had been separately weighed

"CLEAN AS A HOUND'S TOOTH
WITH THE SWISH OF A DAMP CLOTH"

with help hard to get FORMICA helps keep up hospital morale

The hospitals fortunate enough to install Formica laminated plastic as decorative panelling and as bedside and overbed table tops and furniture tops are now reaping these benefits.

1. **Less time spent cleaning—more time for patients.**
   Formica tops can be washed with ordinary soap and water, without damage and as easily as washing a china dish.

2. **No refinishing costs now or ever.**
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   The Formica now in use is in many beautiful colors that have plastic richness and limpid depth. In many hospitals the decorators have combined them to create breath-taking effects which speak the language of serenity and soothing luxury to employees, patients and visitors.

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(2 ounces lean, ½ ounce fat). Accompanying this were two good-sized potatoes (8 ounces) and a liberal helping of cabbage. The pudding was junket, made with a half pint of milk (carbohydrates, 77.5, protein, 25, fat, 22).

Anyone in need of a specially prescribed diet is welcome at the invalid kitchens. They are established in big industrial centers of London and, usually, where a hospital has asked for one to be opened, showing the need for the service. The meal is costed to meet the finances of the patients. No meal costs more than one shilling and sixpence, but, in some cases, where the income is extremely small or the calls on it are large, it may cost no more than twopence.

The kitchens are not considered by the organizers or the customers as a charity, but more as an established medical service. Patients who bring their diet sheets to the kitchens are educated to understand the need for exact weighing of their food and for keeping strictly within the limits of their diets. The kitchens are also working with the hospitals or clinics, reporting on the progress of the people they have taken under their care and even carrying out, in cooperation with the hospitals and the patients, research and experimental work in feeding their patients.

"Diseases and complaints seem almost to run in districts," I was told by K. Lulham, who has been the organizing secretary of the invalid kitchens of London since they began. "In Acton, a factory district, for instance," she added, "our invalids are chiefly gastrics, with some diabetics. In Lambeth, which is more residential, we have a considerable number of expectant mothers, who come to us when there is some complication calling for, say, an albumen diet.

"At Bethnal Green we are taking care of a lot of old people. The district has been heavily bombed. Those with children have left, but the older folk refuse to go. They stand the bombs, but to desert what is left of their homes might kill them. At all the branches there are a number of people needing a specially balanced diet for gradually building up to health and strength. These are the amputation cases, which, of course, showed an increase as a result of the flying bomb attacks."

Kitchens Bombed Out

The developing of substitute foods is not the only problem for the kitchens. Lying as they do in the more crowded parts of London, they are all, according to enemy tactics, in "target areas" and have suffered severely from air raids. One kitchen, twice hit and repaired in the blitz of 1940, has now been completely razed by a flying bomb. Only here has the service had to be suspended—merely because the district around has been so completely demolished that there are no premises into which it could move.

The Bethnal Green kitchen, blasted by a flying bomb, completed a repair job in three days, only to receive a direct hit a forthnight later. But the kitchen staff has taken over a room in a building near by and, here, with great difficulty over cooking and lack of sufficient space for serving, it is carrying on its work. Southwark's kitchen, partly gutted by a fire started by an incendiary bomb, was saved by its patients, some of whom are Heavy Rescue men. Draughty through the total lack of windows

NUTRITION AND THE TIME FACTOR

in Convalescence

In the absence of complications, the speed with which strength and vigor are regained after surgery or prolonged illness, depends largely on the patient's nutritional status. Under an optimal intake of all essential nutrients, the patient's progress is considerably faster. Careful planning of routine diets therefore becomes a matter of importance.

Ovaltine is a valuable component of the high-caloric, high-vitamin diet. This delicious food drink, made with milk, is readily accepted by the patient, although many other foods may be refused. Its rich store of biologically adequate protein, readily utilized carbohydrate, highly emulsified fat, B complex and other vitamins, and essential minerals aids in overcoming nutritional deficiencies when present, and in their prevention.

Patients enjoy Ovaltine even if given several times daily. It breaks the monotony of many diets, and is accepted with relish both as the mealtime beverage and between meals.

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Ovaltine

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,* provide:

PROTEIN	31.2 Gm.	VITAMIN A	2953 I.U.
CARBOHYDRATE	62.43 Gm.	VITAMIN D	480 I.U.
FAT	29.34 Gm.	THIAMINE	1.296 mg.
CALCIUM	1.104 Gm.	RIBOFLAVIN	1.278 mg.
PHOSPHORUS	.903 Gm.	NIACIN	7.0 mg.
IRON	11.94 mg.	COPPER	.5 mg.

*Based on average reported values for milk.

and doors, it nevertheless continued to serve meals the same day.

The invalid kitchens may point the way to general facilities for delicate people who require special diets. At present, they prepare one meal a day for patients, but they could for all.

Their contribution to the Allied war effort should not be forgotten. Not only have they made the lot of invalids better, but they have made it possible for many of these invalids to take up, or to continue in, important war work.

Two Angles on Eggs

Preserving and Purchasing

APRIL seems an appropriate month to learn some fresh facts on preserved eggs and to preserve some old truths about purchasing fresh eggs.

Preserving Eggs

First, let's consider egg donations. The annual Easter egg shower at Wesley Hospital, Chicago, brings in more than 2000 dozen. The goal of the 1945 egg appeal of Lutheran Home for Orphans and Aged at Germantown, Pa., has been set at 5000 dozen.

The cold storage method of preserving these donated eggs is not ideal, as any dietitian can testify, for the color and shape of the yolk and the albumen content of stored eggs undergo changes. Moreover, the eggs develop a faint to strong odor. There is deterioration, too, in the beating or foaming properties of eggs that have been stored.

Newly developed is the flash heat treatment of eggs. Alexis and Anastasia Romanoff, working at the Agricultural Experiment Station at Cornell University, have perfected this treatment. A five second exposure of fresh eggs to boiling water forms a thin protective film of coagulated albumen adherent to the shell membrane. Eggs thus treated, when stored for twelve months in a refrigerator at 5° C. (41° F.) show well-preserved albumen, a light and well-shaped yolk and give no objectionable odor.

Untreated eggs stored in the same refrigerator show watery albumen, a dark yolk frequently stuck to the shell and a pronounced odor. These Cornell University research workers declare that the quality of twelve month old eggs treated by flash heat is equivalent to about that of three months' old untreated eggs kept under similar refrigerating conditions. So little change takes place in the treated eggs that many fertile eggs are able to hatch even after the flash heat treatment.

The flash method of treatment is said to cause little change in the beating power of eggs.

The important point to remember, according to the Romanoffs, is that a five second exposure in boiling water is normally the upper limit of heat treatment of eggs in order to avoid the undesirable appearance of a film of coagulated albumen. No thermostatic control or stirring device is needed in treating the eggs,

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the experimenters point out; the procedure is simple enough to be carried out by ordinary kitchen help under supervision.

Special considerations in the flash heat method of preservation are the age of the eggs and the altitude at which the treatment is being given. Older eggs require a period of exposure shorter than five seconds. In high altitudes where the boiling point of water is below 100° C. (212° F.) it probably will be necessary to lengthen the period of exposure.

Eggs treated by the flash heat methods can be kept at room temperature (70° F.) for some time without losing the characteristics of freshness.

Since this research has not been tried on a commercial scale or by hospital dietitians, to our knowledge, it might be well for the dietitian who gets gifts of eggs or makes large purchases while the price is low to do a little experimenting on her own.

She could treat a small number of eggs by the flash heat method, using eggs preserved by the regular cold storage method as controls. The results of her experiment would be of interest to other readers of this department, it is certain.

Weight Table for Eggs

Grade	*Min. Net Weight of 30 Doz.*
Jumbo	52 lbs.
Extra Large	48½
Large	45
Medium	40
Small	34

Buying Eggs

Some excellent advice on purchasing eggs is given by H. P. Schwarzman, director of Hospital Purchasing Service, in a recently issued *Commodity Bulletin*.

On the matter of weights, the hospital's receiving department should have accurate scales and weigh the cases as they come in. The weight table given below shows the net weights, minus crates and their fillers. The average wood crate with flats and fillers runs from 11½ to 12 pounds (corrugated or fiberboard about 4 pounds less), Mr. Schwarzman asserts, so if the hospital is paying for medium sized eggs, the wood cases should weigh from 51 to 52 pounds gross.

Often the price spread between medium and large sizes is as much as 5 cents a dozen, or $1.50 a crate. If the hospital is paying for large eggs (from 56 to 57 pounds gross to the case) and is receiving medium grade eggs (from 51 to 52 pounds) it can be out of pocket $15 on only 10 cases of eggs a week.

When it comes to grades, the suggestion of the Hospital Purchasing Service is that the hospital insist on receiving eggs that have been inspected and graded by the Department of Agriculture and on finding evidence of this inspection.

If the hospital has standardized on Grade A eggs for boiling, poaching and frying, it should insist that its supplier send this type of eggs only. If Grade B is satisfactory for such uses as scrambling, omelettes, cooking and baking, then that is the grade the hospital should order and pay for. The important point is to see that the institution is receiving the weight and grade of eggs requested and being paid for.

"HEAT-TREATED TUMBLERS LAST 5 to 6 TIMES LONGER"

says ROBERT JOLLY

Administrator
Memorial Hospital
Houston, Texas

MR. ROBERT JOLLY, past-president American Hospital Association, knows the importance of dependability and long-lasting service when it comes to dietary equipment.

At the Memorial Hospital, the management and patients give high praise to Libbey Heat-Treated Tumblers from a quality and safety standpoint.

The Libbey Heat-Treating process adds a stubborn strength to Safedge tumblers—is a new means of lengthening tumbler life. Libbey Heat-Treated Tumblers have that extra strength to stand up and take the thermal shocks of constant sterilization.

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MEMORIAL HOSPITAL
HOUSTON 2 TEXAS

January 20, 1945

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Division of
Owens-Illinois Glass Company
Dallas , Texas

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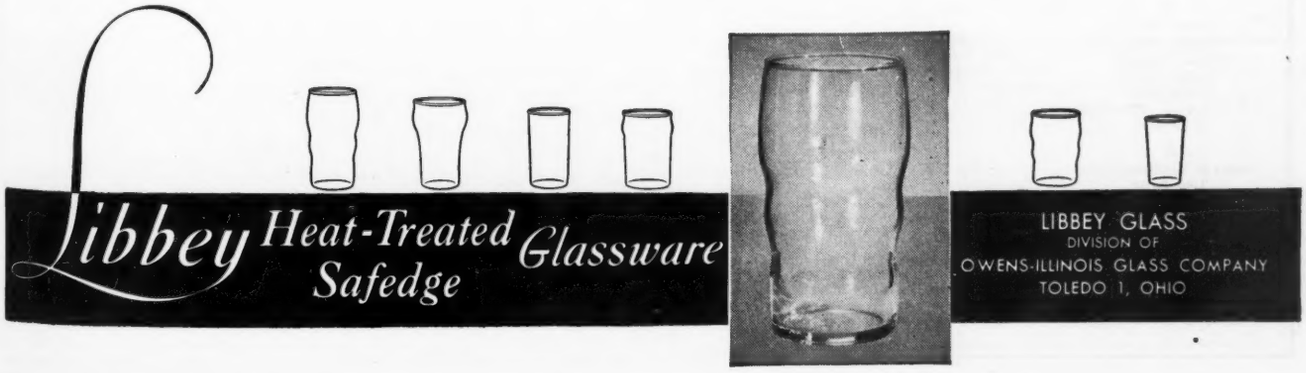
If we can speak a word to any of the other Hospitals about your products, we will be glad to do so.

Enclosed you will find a glossy photograph of our Hospital. Also find a copy of HEART THROBS which we sent out at Christmas time.

Sincerely yours,

Memorial Hospital, Houston, Texas. During 1944, the hospital served 576,441 meals, an average of 1,580 per day. Memorial Hospital admitted over 20,000 patients.



Menus for May 1945

Gail Elliott Moulton

1
Oranges
Soft Boiled Eggs
•
Cream of Carrot Soup
Cereal Nut Loaf, Parsley
Creole Sauce
Buttered Asparagus
Apple and Celery Salad
Boston Cream Pie
•
Chicken-Noodle Soup
Vegetable Soufflé
Baked Potatoes
Pear-Cherry Salad
Ice Cream

2
Baked Apple
Bacon, Nut Toast
•
Clear Broth
Liver
Creamed Potatoes
Buttered Beets
Orange, Date, Watercress Salad
Snow Pudding
•
Vegetable Soup
Creamed Eggs and Olives on Toast
Stewed Tomatoes
Lettuce Heart Salad
Fruit Cup, Cookies

3
Fresh Grapefruit
Bacon
•
Julienne Soup
Hamburgers
Escalloped Potatoes
Mexican Corn
Sweet Relish
Applesauce, Gingerbread
•
Oxtail Soup
Broiled Sweetbreads
Baby Lima Beans
Fruit Gelatin Salad
Cherry Pie

4
Stewed Apricots
Shirred Eggs
•
Vegetable Soup
Broiled Trout, Lemon Slices
Baked Potatoes
Escalloped Tomatoes
Celery
Lemon Pie
•
Consommé
Spanish Rice
Green Beans
Tossed Salad
Baked Custard

5
Sliced Oranges
Scrambled Eggs
•
Creole Soup
Swiss Steak
Boiled Potatoes
Buttered Cauliflower
Sweet Pickles
Prune Whip
•
Scotch Broth
Asparagus, Cheese Sauce
Oven-Browned Potatoes
Waldorf Salad
Sponge Cake

6
Grapefruit
French Toast, Maple Sirup
•
Bouillon
Broiled Chicken
Riced Potatoes
Buttered Brussels Sprouts
Tomato Aspic Salad
Apple Pie
•
Cream of Potato Soup
Jelly Omelet
Celery
Fruit Salad
Chocolate Cake

7
Sliced Oranges
Poached Egg on Toast
•
Creole Soup
Liver and Bacon
Creamed Potatoes
Buttered Corn
Spiced Apples
Fruit Gelatin
•
Grapefruit Juice
Tuna and Noodle Casserole
String Beans
Celery and Olives
Rhubarb Sauce, Cookies

8
Kadota Figs
Fried Eggs
•
Vegetable Chowder
Baked Rice and Cheese
Nut Bread
Buttered Beets
Stuffed Olive and Lettuce Salad
Chocolate Cake
•
Barley-Beef Broth
Spanish Omelet
Wilted Lettuce
Cherry Cobbler

9
Stewed Prunes
Bacon
•
Split Pea Soup
Lamb Chops, Gravy
Mashed Potatoes
Buttered Carrots
Mint Jelly
Hot Applesauce
•
Bouillon
Creamed Chicken on Toast
Peas
Vitamin Salad
Pears, Cookies

10
Tomato Juice
Poached Eggs on Toast
•
Vegetable Broth
Hamburger Loaf With Mushroom Sauce
Mashed Potatoes
Creamed Celery and Green Peppers
Lettuce, Sour Cream Dressing
Fruit Gelatin
•
Chicken-Noodle Soup
Tomato Rabbit With Hard Cooked Eggs on Toast
Tossed Green Salad
Baked Apple in Orange Juice

11
Fruit Juice
Fried Mush, Sirup
•
Tomato Bouillon
Baked Stuffed Fish
Mashed Potatoes
Spinach With Lemon
Tomato and Cucumber Salad
Grapefruit Sherbet, Cookies
•
Cream of Cauliflower Soup
Peppers Filled With Rice, Tomato Sauce
Black-Eyed Susan Salad
Chocolate Cottage Pudding

12
Applesauce
Soft Boiled Eggs
•
Vegetable Soup
Ham Slices in Milk
Lima Beans and Mushrooms
Apple and Celery Aspic Salad
Peppermint Ice Cream, Chocolate Sauce
•
Consommé
Vegetable Plate: Baked Tomatoes, Baked Onions, Peas, Poached Egg, Hollandaise Sauce, Cornsticks
Stewed Apricots

13
Orange Juice
Pancakes, Sirup
•
Fruit Cocktail
Stewed Chicken, Gravy
Mashed Potatoes
Carrots and Peas
Pear and Strawberry Salad
Snow Pudding
•
Cream of Carrot Soup
Tuna and Potato Scallop
Head Lettuce Salad
Butterscotch Sundae

14
Grapefruit Juice
Scrambled Eggs
•
Barley Soup
German Meat Balls
Noodles With Buttered Crumbs
Green Beans
Hawaiian Salad
White Cake, Foamy Sauce
•
Chicken Soup
Sweetbread and Mushroom Croquettes, White Sauce
Green Peas
Chef's Salad
Fruit Gelatin

15
Stewed Prunes
Shirred Eggs
•
Vegetable Soup
Macaroni and Cheese
Hot Slaw
Ginger Ale Salad
Apple Pie
•
Cream of Mushroom Soup
Egg Soufflé
Mixed Fruit Salad
Cup Cakes

16
Grapefruit
Poached Egg on Rusk
•
Tomato Juice
Pork Chops, Cinnamon Apples
Candied Sweets
Boiled Onions
Lettuce Salad, Sour Cream Dressing
Prune Whip
•
Vegetable Soup
Creamed Chipped Beef on Toast
Mixed Fruit Salad
George Washington Cake

17
Orange Slices
Bacon and Eggs
•
Clear Soup
Veal Croquettes
Escalloped Potatoes With Onions
Parsley Carrots
Tomato and Celery Salad
Orange Whip
•
Vegetable Broth
Baked Potatoes Filled With Minced Ham
Beet Salad
Apple Pudding

18
Baked Apples
Scrambled Eggs
•
Cream of Corn Soup
Baked Fish, Horseradish Sauce
Parsley Potatoes
Spinach With Egg
Pear and Cream Cheese Salad
Gingerbread
•
Vegetable Soup
Welsh Rabbit Over Asparagus on Toast
Tomato Aspic Salad
Buttermilk Cake

19
Grapes
Canadian Bacon
•
Bouillon
Tongue in Raisin Sauce
Green Peas in Noodle Nest
Orange and Cress Salad
Spiced Pudding
•
Vegetable Soup
Poached Eggs on Canned Corned Beef Hash
Green Beans
Orange Shortcake

20
Orange Juice
French Toast, Sirup
•
Tomato Juice
Chicken Fricassee
Mashed Potatoes
Hot Biscuits
Creamed Green Peas and Onions
Grapefruit Salad
Coffee Bavarian Cream
•
Cream of Mushroom Soup
Deviled Eggs, Potato Salad, Stuffed Celery, Carrot Sticks
Chocolate Cake

21
Stewed Rhubarb
Scrambled Eggs
•
Cream of Carrot Soup
Ham Steak With Corn Fritters
Coleslaw
Steamed Apple Pudding
•
Purée of Asparagus
Hot Egg and Cheese Sandwich, Tomato Sauce
Tossed Green Salad
Ice Cream, Cup Cakes

22
Grapefruit
Creamed Eggs on Toast
•
French Onion Soup
Baked Tomatoes Filled With Eggs on Toast Rounds
Buttered Asparagus
Fruit Cup, Cookies
•
Corn Chowder
Macaroni and Meat Casserole
Green Salad
Boston Pie

23
Kadota Figs
Soft Boiled Eggs
•
Grapefruit Cocktail
Roast Lamb, Dressing, Mint Sauce
Browned Potatoes
Buttered Broccoli
Tomato Salad
Bavarian Cream
•
Split Pea Soup
Sea Food au Gratin
Beet Salad
Orange Cake

24
Stewed Apples
Bacon and Eggs
•
Vegetable Soup
Hamburger Patties, Brown Sauce
Escalloped Potatoes
Buttered Beets
Fruit Salad
Cheese Cake
•
Tomato Soup
Chipped Beef, Potato Chip Casserole
Tossed Green Salad
Apple Betty

25
Tomato Juice
Fried Mush, Sirup
•
Julienne Soup
Baked Halibut
Mashed Potatoes
Harvard Beets
Carrot Sticks
Suet Pudding, Caramel Sauce
•
Cream of Mushroom Soup
Tuna Salad
French Fried Potatoes
Olives
Chocolate Sundae

26
Apple Juice
Bacon and Eggs
•
Consommé
Beef Stew With Vegetables
Hot Biscuits
Tomato Salad
Apple Batter Pudding
•
Fruit Cup
Scrambled Eggs With Buttered Noodles
Cabbage Salad
Berry Pie

27
Oranges
Scrambled Eggs
•
Vegetable Soup
Roast Chicken
Mashed Potatoes
Summer Squash
Olives, Pickles
Strawberry Ice Cream
•
Tomato Bouillon
Cold Cuts
Au Gratin Potatoes
Endive Salad
Chocolate Cake

28
Fruit Juice
Poached Eggs
•
Barley Broth
Liver and Bacon
Parsley Potatoes
Frosted Spinach
Coleslaw
Zwieback Pudding
•
Corn Chowder
Baked Stuffed Potatoes
Egg and Tomato Salad
Applesauce, Gingerbread

29
Grapefruit Juice
Bacon and Eggs
•
Chicken Broth With Rice
Tuna and Macaroni Casserole
Green Beans
Carrot Sticks, Radishes
Peach Ice Cream
•
Cream of Mushroom Soup
Club Sandwiches
Potato Chips
Banana and Chopped Nut Salad, Peanut Dressing
Sponge Cake

30
Orange Juice
Boiled Eggs
•
Tomato Soup
Braised Beef Heart, Gravy
Mashed Potatoes
Buttered Asparagus
Celery, Green Onions
Fruit Cup, Cookies
•
Consommé
Creamed Ham and Peas on Toast
Buttered Beets
Iceberg Salad
Baked Apples, Wafers

31 Orange Juice, Shirred Eggs • Cream of Corn Soup, Vegetable Plate: Baked Stuffed Potato With Cheese, Beets, Broccoli, Squash, Baked Pears • Cream of Celery Soup, Meat Croquettes, Spanish Sauce, Fruit Salad, Hot Biscuits and Strawberry Jam

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Don't Let Grease Clog the Kitchen Routine

R. B. CRAWFORD, M.D.
Superintendent, Lakewood Hospital, Cleveland

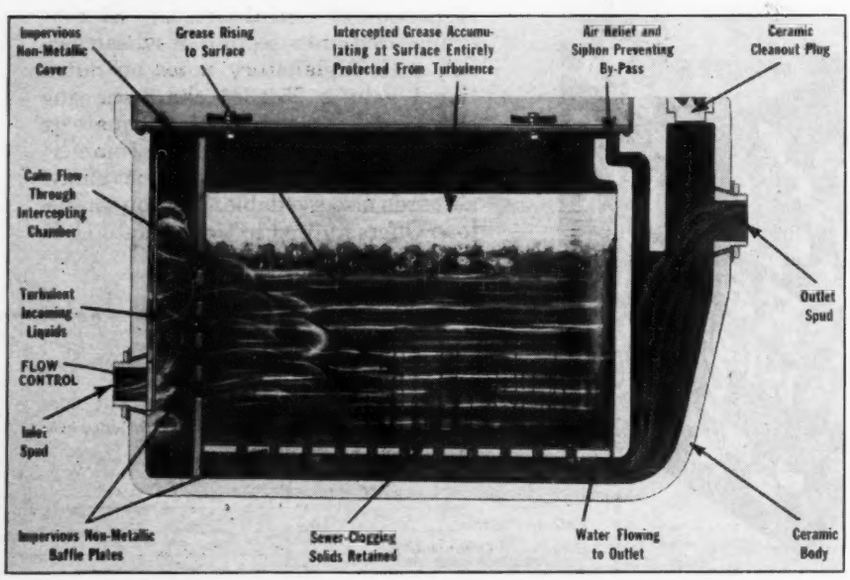
ONE of the most serious threats to regularity of food service schedules is a grease-clogged drain or sewer. Whenever a drain becomes clogged, as often happens wherever meals are served on a mass basis, it prevents the use of the kitchen sinks and stops the washing of dishes. This, in turn, limits the supply of clean dishes and hinders the work of the kitchen staff, retarding the kitchen routine and serving schedules.

The amount of grease substances that enters drain pipes is estimated by the American Restaurant Association to average more than 14 pounds per thousand meals served.

These grease substances are by-products of meats, cooking fats, soap products and salad oils and flow into drainage lines from kitchen sinks, dishwashing machines and other sources. Upon entering the drain pipes they cool and congeal in masses that cling to the sides of pipes, accumulating until the flow of waste water is partially or completely stopped.

The only satisfactory method of reopening a grease-clogged drain is by "rodding" out the pipes, an expensive and trouble-making process that involves digging up and cleaning out or replacing the pipes. All other methods are ineffectual. Chemical solvents, while they may loosen part of the grease, are injurious to pipe fixtures and never reach the basic grease accumulations. Electric tubings or "snakes" may remove solids and substances, such as silverware and potatoes, but they have not proved successful in removing grease.

Because rodding pipes is costly and dirty, involves the removal of sections of flooring and disrupts hospital serving schedules, it should be avoided. The only practical solution of the clogged drain problem is to keep the grease from getting into the pipes by running the waste water through a receptacle that will remove the grease near the opening.



Modern interceptors remove more than 90 per cent of the grease.

Grease interceptors or grease traps, as they are sometimes called, keep trouble-making grease substances out of drains by intercepting them from the waste water. They have long been a standard part of the equipment of many hospitals that have realized the importance of having their drainage system functioning at all times.

For economy-minded administrators, grease interceptors perform another service in addition to maintaining serving schedules. They reduce maintenance expenses and plumbing bills incurred by opening stopped-up pipes. Both plumbing methods of reopening clogged drains —by rodding and by electric tubing —are expensive because of the labor and time elements involved. It is not unusual for an institution to spend $500 or $600 annually on plumbing bills to reopen clogged drains, which would pay the price of several modern grease interceptors. A glance at the classified section of a telephone directory will disclose numerous plumbers bidding for your business to clean out clogged drains and sewers.

For larger hospitals that have their own plumbing maintenance crews, grease interceptors, by avoiding clogged drains, save the manpower necessary to reopen drains and sewers.

The first essential of effective grease interceptors is the reduction of the turbulence of the waste water, which enters grease interceptors as swiftly as the water that flows down a rapid. This is done by perforated baffle plates opposite the inlet. The resulting quiet flow of the water permits the "flotation" principle (the natural tendency of grease to rise to the surface of the water) to function at its highest efficiency, since the more completely turbulence is eliminated, the greater the degree of separation possible. Such interceptors have been tested by hydraulic laboratories and have been found to intercept more than 90 per cent of the grease in waste water.

The most important (but often overlooked) factor concerning the maintenance of grease interceptors is that the devices, no matter how well designed, do not dispose of grease. They merely collect it in an inter-

cepting chamber from which it must be removed periodically.

Many maintenance men have experienced considerable trouble by neglecting to clean out grease interceptors. This is only natural. After a grease interceptor reaches its capacity it will not intercept further. When it becomes overloaded with grease, the flow of waste water through it is impeded.

The cleaning periods of grease interceptors vary according to their size and the amount of grease in the waste water. Any reliable plumbing contractor can, upon examination, recommend cleaning periods, which may vary from once or twice a week to once or twice a year. It is always advisable that the responsibility for emptying a grease interceptor be placed on the maintenance department rather than the kitchen employes, as the former has a better understanding of the importance of maintaining equipment.

Different drainage systems require different sizes of grease interceptors, depending upon the capacity of the drain pipes, and it is important that interceptors of the proper size be installed. They should be installed as near as possible to the sink, dishwashing machine or other sources of grease, intercepting the grease before it reaches a level section of piping where it readily clogs. The units can be set on the floor, above or below it, whichever is convenient.

Grease interceptors formerly were made almost exclusively of cast iron, but because of the great need for metals for war uses, they are now made of ceramic material which has proved so successful that the use of this material, as well as cast iron, will probably be continued in peace time.

Rubbish Disposal Simplified

EDWARD HALLINAN
Chief of Maintenance Department
Baker Memorial Building
Massachusetts General Hospital, Boston

EVERY hospital has an area in which rubbish accumulates and distant areas in which the rubbish is disposed of.

At Massachusetts General Hospital in Boston, a simple and effective system has been designed so that the rubbish barrels throughout the hospital need not be emptied into another container on the way to the rubbish disposal point.

The barrels illustrated are simply empty oil drums with the tops carefully removed and all edges trimmed and ground to make them entirely safe. Handles made of steel bars are welded onto the barrel to facilitate lifting.

For each barrel a dolly, or four caster carrier, has been made. The frame is of angle iron securely welded. Rubber bumpers are fastened to the top of the carrier so that no noise is produced on rolling the carrier along the corridor.

The dolly should be constructed with all four casters free to swivel. The diagonal of the dolly should be approximately 1 to 1½ inches less than the inside diameter of the bottom of the drum. By having all barrels or drums of identical size the dolly and drums are interchangeable. It is wise to paint the barrels a conservative color that does not show finger marks. The dollies should be painted a brilliant yellow or another conspicuous color so that they can be seen if they are left on the floor.

The procedure used is simple. The rubbish barrel on the dolly is rolled into the rooms and closets or wherever it is intended to go. When full of rubbish it is taken to the elevator and sent to the disposal station. A barrel full of heavy rubbish is easily moved, and one person can easily handle two.

In many hospitals it is essential that the rubbish be dumped on the floor in order more easily to discover silverware, linens and other valuables before the rubbish is burned.

If the hospital technic should involve the loading of the barrel on a larger truck it is easy to have this truck bring empty barrels to exchange for the full ones.

The nursing department is enthusiastic about these barrels because they are large, easily moved, fireproof, readily cleaned and not eyesores. The maintenance department likes them because it is the only way to preserve good floors which otherwise will gradually be destroyed by driving unwheeled barrels over them.

The employes and the housekeeping department like them because they are easy to move and can be lifted, emptied and replaced on the dollies without back bending.

The barrels thus converted have been in service for a considerable period so that their use does not conflict with the War Production Board's ruling that certain types of drums must be reused regardless of whether they were purchased by the hospital.

With the wheeled carrier one man can easily handle two drums full of rubbish at once.

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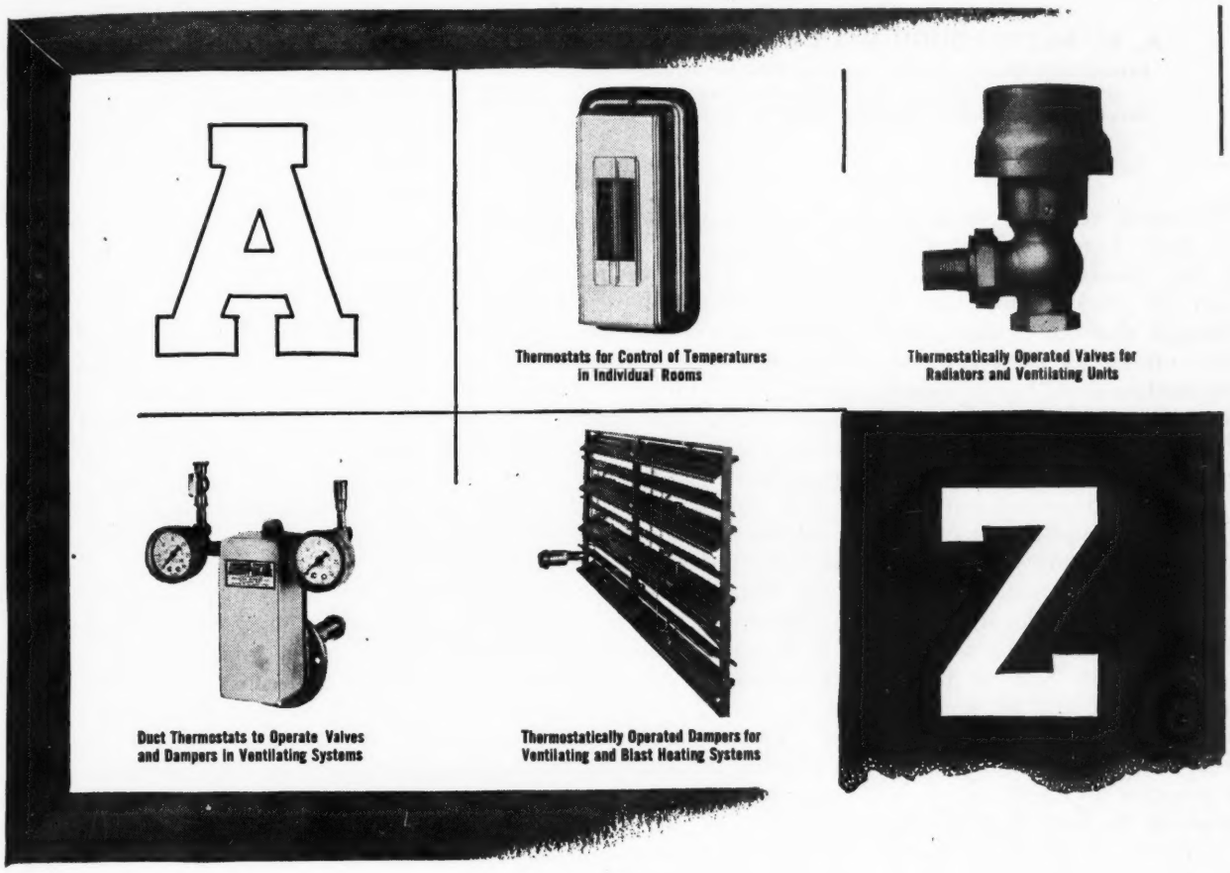

Johnson not only manufactures a complete line of precision-built thermostats and controllers but designs the whole temperature control system from "A to Z" in cooperation with hospital authorities and their architects. Then Johnson installs the system and puts it in perfect operating order before it is turned over to the operating engineer. Years of careful training and experience enable Johnson temperature control experts to bring seasoned knowledge to bear on the proper application of every element in a complete temperature control system.

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Training Program for Employes

A. M. McCULLOUGH and DORIS L. DUNGAN

Respectively, Public Service Training Director, Connecticut State Department of Education, and Executive Housekeeper, Hartford Hospital, Hartford, Conn.

FOR several years, the Connecticut State Department of Education has carried on a training program for school custodians. It was thought that out of that training program one for hospital housekeeping workers could be established. To determine this fact, a conference was held with the executive housekeeper and the assistant business manager of the Hartford Hospital, Hartford, Conn., and the director of public service training of the State Department of Education. This conference revealed that the transferral of the program of school custodial training direct to hospital housekeeping could not be done, so it was decided to study the housekeeping problems of the hospital and establish a program for them.

A study of the field disclosed that there were two phases of the housekeeping work: (1) cleaning, (2) establishing the proper attitudes among the workers.

The cleaning program first was studied on the basis of cleaning activities and the cleaning of surfaces.

After careful study and thorough discussion it was decided to use cleaning activities; to use locations as the basis for cleaning jobs, and to develop workers' attitudes.

The first step was to decide what cleaning activities were used in the hospital. They were found to be: dusting, sweeping, scrubbing and mopping, cleaning polished, glazed and porcelain surfaces, waxing and washing walls and windows.

The second step was to determine the various locations in the hospital where one or more of these activities would be used. It was found that there were more than 50 such locations, of which the following are typical: shops, offices, living room, patients' rooms, wards, bathrooms and kitchen.

The third step was to analyze the workers' relationships and feelings toward the job of hospital cleaning. The following attitudes were decided upon: (1) human relations, (2) housekeeping responsibilities, (3) safety, (4) sanitation and (5) fire prevention and protection.

The decisions reached on these problems determined the next step, *i.e.* that of developing a course of study, which the committee prepared as follows:

1. A teaching outline for each of the activities to be taught was made out.
2. A teaching outline of the jobs in cleaning for the 50 locations to be taught was set up.
3. The 50 cleaning jobs were analyzed carefully so as to make sure that all the steps in doing the specific job were listed.
4. The various attitudes to be created among the workers were analyzed in detail. Suggested ways of bringing them to the housekeeping staff were listed.

It was decided that the cleaners' training program should be given by the supervisors of the hospital housekeeper's staff. This decision meant that a teacher training program needed to be established for these workers.

The teacher training needs of the housekeeping supervisors were analyzed and the findings resulted in selection of the following topics as the basis for the program.

1. What is teaching?
2. How do people learn?
3. Comparing different educational programs.
4. Assembling, selecting and organizing teaching material.
5. Analyzing cleaning jobs and activities.
6. Making and improving lesson plans.
7. Conducting a class.

A. M. McCullough of the State Department of Education presented the basic teacher training work and V. C. Jorgensen of the Hartford board of education taught the activities.

The teacher training work in general covered the following:

1. Teaching and learning were compared and their supplementary and complementary phases clearly set forth.
2. Various philosophies of education and their bearing on the work of training hospital cleaners were carefully presented.
3. The difference in the methods of teaching skills and attitudes was shown.
4. A plan for anlayzing the 50 cleaning jobs was outlined and practice in doing so was given.
5. Definite teaching plans for presenting both a skill and an attitude were given the class.
6. Teaching plans were prepared by each member of the class and presented to the group for general discussion and constructive criticism.

The activities were taught in accordance with this general plan:

1. The instructor told what he did in preparation before coming to the class.
2. The activity was introduced by showing what basic reasons were behind the performance of it.
3. The activity in all its phases was demonstrated by the instructor.
4. Each class member was then given the opportunity to perform the activity under the supervision of the instructor.
5. A discussion period followed in which all points in doubt concerning the activity or the teaching plan were cleared up by the instructor.

At the close of the teacher training program is was discovered that there were many other problems to be considered that would help the supervisors in their teaching program. It was decided that once a week a conference would be held during which the staff would conduct a class among the members of the group so that suggestions could be offered or that conferences would be held based upon the teaching problems found as the supervisor carried on the work.

OF MYXEDEMA

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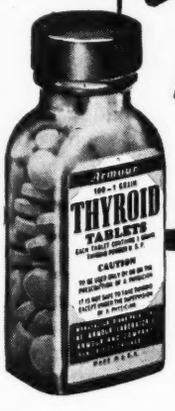

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NEWS IN REVIEW

Hospital Service Commission Authorizes National Enrollment Plan for Blue Cross

The establishment of a national Blue Cross enrollment service in Chicago with a branch in New York City was authorized by the Commission on Hospital Service, meeting in New York on March 13 to 15. This office is to enroll national accounts and to assist local plans in rural, individual and communitywide enrollments. The service will also give special attention and assistance to areas with low enrollment. A budget of from $25,000 to $30,000 per year has been underwritten by special contributions from interested plans to start the work.

The commission also approved the plan for reciprocity of service benefits as it was presented by the committee on hospital relations. Under this plan subscribers can quickly and easily obtain benefits through the local plan when they are away from home. Plans are not insisting that subscribers who move must enroll in the plan to whose area they move.

To conform with O.D.T. regulations, there will be nine small regional conferences of plans east of the Mississippi during the spring and summer and one additional conference in Denver. Also, those plans whose personnel cannot attend any of these regional conferences will be visited by staff members of the commission. The conferences will deal with methods of enrollment, office organization and public relations.

Blue Cross plans were urged to aid in state hospital surveys by a resolution approved by the commission. Directors of the Michigan, Iowa and Missouri (St. Louis) plans are now members of the state hospital survey commissions of their respective states.

Subscribers should have a larger voice in the affairs of Blue Cross plans, the commission recommended, and it urged all plans to expand their activities for providing subscriber representation by the development of subscribers' councils or otherwise.

James A. Fulton, president of the Life Insurance Association of America, representing 70 of the largest life insurance companies, told the commission and committee members that life insurance and Blue Cross are "soldiers in a common cause."

The Aetna Insurance Company, however, announced following the meeting that it is now prepared to offer hospital and surgical coverage without any of the other types of group insurance, provided 50 people enroll in each place of employment. Thus, this company will intensify its competition with Blue Cross plans.

Possible methods of cooperation between medical and hospital plans were discussed but no final steps were taken to effectuate a definite relationship. Medical plans that are affiliated with Blue Cross plans now provide protection to 1,500,000 persons.

Medical Associations Cancel Conventions

In cooperation with the war effort, many medical societies are canceling annual meetings scheduled for this year. The American Psychiatric Association, the American Orthopsychiatric Association, the Society of American Bacteriologists, the Federation of American Societies for Experimental Biology and the American Public Health Association are the most recent to announce cancellation of their annual meetings.

The American Psychiatric Association, oldest medical society in the country, has held meetings every year since 1844 except in 1861, when it was recorded that "no meeting was held on account of the disturbing conditions of the country."

Hospital Meetings Off

The Hospital Association of Pennsylvania, which has also canceled its annual gathering, scheduled for April 18 to 20, has announced that present officers and trustees will continue to function until the next convention at which time election of new officials will proceed as if no convention had been missed.

The board of directors of the Minnesota Hospital Association will hold a spring meeting on May 4 and 5 at the Nicollet Hotel, Minneapolis, in place of the usual spring convention.

The board of trustees of the New England Hospital Assembly voted to arrange a meeting of committee chairmen and members selected on a geographical basis to carry on the business of the assembly in place of the usual annual meeting. The gathering will be held in Boston April 6 and 7 and each state will have a minimum of five or six representatives.

The presidents and the secretaries of each of the New England state associations are among those invited to attend.

New Haven Hospital Sets Up Priorities on Patient Admissions

A priority plan for the admission of private and semiprivate patients at New Haven Hospital, New Haven, Conn., was made effective on March 5. Under this plan, patients are admitted in the following order: emergencies immediately; then, if space is available, group I patients and finally, if space is available, other patients in chronologic order. Waiting lists are kept separately for group I and for other patients. If a patient twice refuses admission when called, he goes to the bottom of his list.

Emergencies are defined as follows: acute abscess; Addison's disease (in crisis); acute appendicitis; severe blood disease; acute burns; cardiac disease in collapse; acute cholecystitis; coma; acute communicable disease; cranio-cerebral trauma with subdural or extradural hematoma; croup; diabetes complicated by presumptive acidosis; severe diarrhea and vomiting; embolus with gangrene of arm or leg impending; empyema and severe feeding problems.

Other diagnoses in the emergency group are: foreign bodies in bronchii, esophagus, eye, gastro-intestinal tract or trachea; fracture or dislocation of spine; intervertebral disc rupture if incapacitating; gangrene; acute glaucoma; congestive or anginal heart failure; severe hemorrhage; hypertrophic pyloric stenosis of infants; severe infections; severe injuries; mediastinitis; meningitis; severe metabolic disorders; nephritis, if acute or complicated by uremia; obstruction of genito-urinary system (severe), intestine or common duct; acute pancreatitis; peritonitis and complication; complicated or tubal pregnancy, normal delivery, premature birth; pulmonary pyocyst; detachment of retina; acute rheumatic fever; rupture of spleen; tetanus; brain tumor; severe hemorrhage or obstruction or perforation caused by ulcers.

Group I patients are those with the following diagnoses: chronic lung abscess; severe ulcerative colitis; cancer; complicated patent ductus; subacute bacterial endocarditis; toxic thyroid or obstruction of respiration caused by thyroid; spinal cord tumor, and therapeutic abortion.

All emergency admissions are to be reviewed each week to see if they conform to the rules.

Casualties Reach 1200 Daily

Approximately 1200 soldier casualties a day are arriving in the United States from overseas; 35,000 arrived last month and 40,000 are expected next month.

800,000 Casualties Transported by Air

WASHINGTON, D. C.—Air evacuation of war casualties is proceeding at the rate of more than 2000 per day, O.W.I. announced on March 9. Approximately 800,000 sick and wounded patients of the American and Allied forces have been transported by the A.A.F. in all theaters in the last two and half years.

Although many of the patients are critically ill, the death rate in flight has been just five thousandths of 1 per cent. In all of 1944 only 28 patients died in flight. The accident rate has been lower than for almost any other form of transport.

More than 1200 flight nurses have been trained by the A.A.F. All transport aircraft flying the established A.T.C. routes and all troop carrier planes serving overseas are equipped for conversion to litter planes in a matter of minutes. Even gliders and helicopters have been equipped for ambulance service, although their use has been extremely limited. The average miles per patient was 5077 in December 1944 with an average of 27 hours per patient.

Experience has proved that patients with stomach or head wounds, who formerly were rejected for air travel, now may be safely flown at low altitudes. Prompt return to U. S. hospitals is said to result in complete cures in 85 per cent of mental disease cases, many of whom would be adversely affected by long sea journeys. Special precautions are taken during their evacuation.

Patients Protest Scarcity of Meat

A lack of meat on the hospital menu was the reason given by a tuberculous patient who left Gallinger Hospital in Washington recently. Another threatened to leave unless the shortage was relieved immediately.

Patients have been fed 4 ounces of meat five days a week, although the minimum requirement for tuberculous patients is 8 ounces. An investigation of the situation reveals that contracts of the Federal Procurement Division for meats during March, April, May and June for federal and district institutions in Washington were not adequate to supply even the district's needs, but negotiations made by the district purchasing officer in the open market may improve the situation during the next three months.

Oil Magnate Gives $4,000,000

One of the largest individual gifts to hospitals ever reported was the $4,000,000 recently given by H. R. Cullen, prominent oil man of Houston, Tex., to four hospitals in that city. A fund of $1,000,000 was given to each of the following: Hermann Hospital, Memorial Hospital, Methodist Hospital and to a group of Episcopalians to found an Episcopal hospital. One of the hospitals had been just ready to put on a fund-raising campaign which now becomes more or less unnecessary.

Westmoreland Fund Over Top

The $500,000 campaign of Westmoreland Hospital, Greensburg, Pa., to erect an addition to its present facilities was oversubscribed by $1826. The fund will permit the hospital to increase its bed capacity to 320 beds. Ketchum, Inc., of Pittsburgh directed the campaign.

Fund Campaign Opened

A $1,000,000 fund campaign has been opened by Roosevelt Hospital in New York City for an expansion of its services and for a new five story building for accident-emergency cases, out-patient clinics and semiprivate accommodations.

Federal Participation Can Be Advantageous, Speaker Declares

"Federal participation in health work, if properly organized and with local and largely professional rather than federal control, promises many advantages." This opinion was voiced by Dr. William W. Herrick, president of the New York Academy of Medicine, speaking March 6 on the subject of "Hospital Care in the Future" before the third annual symposium sponsored by the United Hospital Fund of New York in cooperation with the Greater New York Hospital Association. Doctor Herrick continued, "Federal aid means some degree of federal control—a prospect which many view with reluctance. It behooves hospital management and professional staffs to cooperate in this seemingly inevitable enlargement of government activity in hospital distribution and construction and, so far as is possible, to make local control so efficient that federal interference in management shall be minimal."

Blue Cross administrators and trustees are striving for growth and greater service in many ways, C. Rufus Rorem, director, A.H.A. Hospital Service Plan Commission, told the audience. Among these are coordination of all hospitals—including governmental—into unified programs for each community or state; government assistance to permit the enrollment of low-income groups in approved voluntary health programs, and coordination with prepayment plans for physicians' services sponsored by the medical profession.

Considerable attention was focused upon the hospital care of children. Those participating in this discussion were Dr. Donovan J. McCune, chief pediatrician, Vanderbilt Clinic, New York; Muriel Gayford, lecturer in medical social work, Bryn Mawr College, and Dr. Milton J. E. Senn, associate attending pediatrician, New York Hospital.

Dietetics Course Offered

To help alleviate the shortage of dietitians in civilian hospitals, Presbyterian Hospital and Montefiore Hospital in New York City will offer a refresher course to dietitians during the six weeks' summer session at Teachers College, Columbia University. Presbyterian Hospital will emphasize food service to patients, the food clinic, the educational program for student nurses, dietitians and medical students and formula room procedures. Montefiore Hospital will offer instruction in menu planning, food ordering, food preparation, food cost accounting, personnel management and diet therapy. Application must be made before May 15 and registration is limited to 15 students.

Cutler Is V. A. Adviser

WASHINGTON, D. C.—Dr. Max Cutler of Chicago has accepted appointment as a member of the special medical advisory group to the administrator of Veterans Affairs, it was announced March 6. He will serve as counselor on tumors of the group which now numbers 16. Doctor Cutler is director of the Tumor Research Clinic and consultant on tumors at the Veterans Administration Hospital at Hines, Ill. He is former director of the tumor clinic at Michael Reese Hospital, Chicago.

Plan Doctors' Office Building

WASHINGTON, D. C.—The Columbia Medical Buildings Corporation announced March 8 that it will build a 10 story $681,800 annex to provide offices for some 75 or 100 doctors returning here after the war. The annex will be designed to meet the latest requirements in the practice of medicine and surgery. Each office will be supplied with compressed air, vacuum and special conduits for radio and television and telephone connections.

Illinois to Increase Budget to Improve State Hospitals

Citing the fact that at Manteno State Hospital there are only 12 doctors and 12 nurses for 6400 patients, Rodney H. Brandon, director of public welfare for Illinois, has asked Gov. Dwight H. Green for a large increase in the budget for the state's mental hospitals. A budget of $85,000,000 for the next biennium for the 22 state welfare institutions was agreed upon by the governor and Mr. Brandon. The budget in the 1943-45 biennium was $41,519,000.

The increased funds will permit pay increases of 15 per cent for those in the lower brackets and 10 per cent for administrative officials. It will also enable the state to employ 12 per cent more attendants. A total of $15,000,000 is included for rehabilitation and hospitalization of returning war veterans, and $10,000,000 for hospital improvements. There are also increases for food and clothing costs.

Mr. Brandon originally asked for an increase of 32 per cent in the ratio of personnel to patients.

In commenting on the increased budget, the Chicago *Sun* said that "patients remain in hospitals far longer than necessary, causing expense measurably higher than would be that of larger, better staffs. Still more to the point, adequate staffs could eliminate the brutalities which now recur with shocking frequency."

New York Plans New Medical Center at End of War

Construction of a new medical center on the site of the present Bellevue Hospital, New York City, to make the city "the most important and the most advanced medical center in the world" is being planned for the end of the war, according to an announcement by Mayor F. H. LaGuardia on March 18.

All but the present administration building, the psychopathic hospital and the tuberculosis building at Bellevue will be wrecked after the war and a 25 to 35 story main hospital will be erected from Twenty-Sixth to Thirtieth streets and from the back of the administration building to East River Drive. The entire block south of this building will become the site of a new nurses' home and training school. The city plans to spend about $12,500,000 on the project.

In addition, New York University is to spend $15,000,000 in building a new college of medicine and a 450 bed semi-private hospital on First Avenue between Thirtieth and Thirty-Third streets, just north of Bellevue. Bellevue will have at least 3200 beds, the mayor said.

British Hospital Group Changes Its Title

The Incorporated Association of Hospital Administrators, which was formed in 1942 by a fusion of the Hospital Officers' Association and the Clerks' and Stewards' Association, has now changed its name to the Institute of Hospital Administrators, according to word that was received from England last month.

The institute is the national professional organization in Great Britain responsible for training and examination of aspirants for responsible posts in the sphere of hospital administration.

Also, an Association of Voluntary Teaching Hospitals of Great Britain was recently formed to deal with the national Ministry of Health, local authorities, universities and other bodies on matters peculiar to the teaching hospitals as such. Membership is open to a voluntary hospital that is the undergraduate teaching center of a university medical school. London hospitals are entitled to three representatives each and provincial hospitals, to four each.

Army Explains System of Allocating M.A.C. Candidates

Although the Medical Administrative Corps officer candidate school at Camp Barkeley, Tex., was scheduled for inactivation the middle of March, Carlisle Barracks, Pa., is continuing its training of candidates. Two classes entered before February 3 and additional classes will enter through April.

An increasing number of qualified personnel is needed in the medical administration field. It is reported, however, that there has been misunderstanding regarding the allotment of quotas and the method of application for officer candidate schools. The Office of the Surgeon General states that no application will be refused consideration on the grounds that quotas have not been allotted to a unit or installation and that quotas to officer candidate schools are not arbitrarily assigned without previous information.

The principal source of officer material is the enlisted ranks of the medical department. The War Department announces that "all warrant officers and enlisted men who demonstrate outstanding capacity for leadership and who possess outstanding qualifications desired in an officer will be encouraged to apply for training."

Housekeeping Course Begun at Cornell

A course in hotel and institution housekeeping management, conducted by Mrs. Crete Dahl, was added to the four year curriculum of Cornell University department of hotel administration on March 8. In the fourteen weekly sessions to be held, Mrs. Dahl will endeavor to coordinate information gleaned by students from their other courses, such as textiles, chemistry, engineering, decoration and psychology, by showing how it applies to housekeeping problems.

It is hoped that various phases of hospital housekeeping can be included in order to give graduates an opportunity to qualify for jobs in either hotels or hospitals.

Mrs. Dahl, who is the hotel education chairman of the National Executive Housekeepers Association, is the author of "Housekeeping Management in Hotels and Institutions" and is head of The Dahls, publishers of business books for the hotel and restaurant fields. Since April 1944 she has been associated with the Hotel Management Employe Training Service.

U. S. Receives Hospital Trains

At least 40 hospital trains to move wounded American troops in Europe and the United Kingdom have been assigned to the United States by Britain under reverse lend-lease. In addition, a number of British ships have been assigned to move United States battle casualties.

Masons Give Iron Lung

An iron lung to be available to 22 counties in southern Illinois has been given to Christian Welfare Hospital, East St. Louis, Ill., by the Mississippi Valley Consistory and Coordinate Bodies of the Scottish Rite Masonry of East St. Louis. The $1800 lung can accommodate one adult or two children at the same time and will be used in the special infantile paralysis ward of the hospital.

Opportunities for Women

The women's bureau of the U. S. Department of Labor has issued two bulletins entitled "Occupational Therapists" and "Physical Therapists." The bulletins are the first of a series on present opportunities and postwar prospects for women in the medical services.

Medical Service Plan Enrolls Morgan Employes

The United Medical Service of New York actually got under way on March 5 by enrolling all of the employes of J. P. Morgan and Company, Inc. The company pays the entire cost of this service for 681 employes and their families, including 80 employes now in the armed forces. The company also is participating in Blue Cross.

Individuals with incomes up to $1800 and families with incomes up to $2500 are entitled to complete payment of physicians' and surgeons' fees for surgical operations, the treatment of fractures and dislocations and maternity care. Employes with higher incomes may be billed for additional fees.

United Medical Service has been officially endorsed by the state and county medical societies.

Just a week later the Missouri Medical Service was launched in St. Louis with 60 per cent of the St. Louis doctors and 40 per cent of those of the state participating. Enrollment at the outset will be available only to present Blue Cross subscribers. Benefits cover medical and surgical care in a hospital, without waiting period except for obstetrics and tonsil and adenoid operations.

Hospital Opening Planned

A new 100 bed hospital at Renton, Wash., was scheduled to open April 1 provided that adequate staff and equipment could be obtained. The $700,000 hospital has been granted government funds for operation for the first six months and it is hoped that it will be self-sustaining after that time.

Add to Nurses' Residence

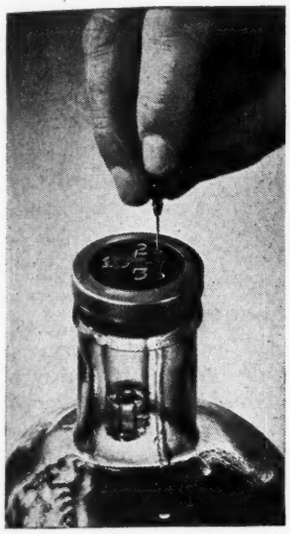
The new addition to the nurses' residence at Geisinger Memorial Hospital, Danville, Pa., was formally opened recently at a reception and tea that followed the commencement exercises at the school of nursing. The three story residence provides living quarters for 78 student and graduate nurses. A portion of the cost of construction was provided under a Lanham Act grant.

Blue Cross Plan Honored

The St. Louis Blue Cross Plan was presented with the annual community service award for 1945 by the Hospital Council of St. Louis at a dinner April 5. The award is given each year to the organization or individual making the greatest contribution to the community's health.

Simplified, Economical Infusions with the 'Infusometer'* Dispenser

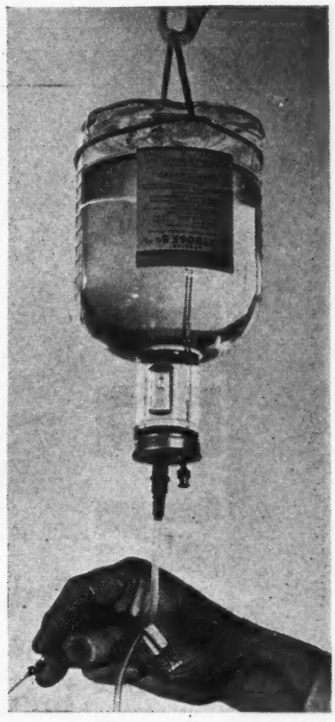
1) *Disposable,* sterile, pyrogen-free, plastic tubing eliminates sterilization routine, insures safe, uncomplicated infusions.
2) *Built-in dripmeter* facilitates removal of air from tubing.



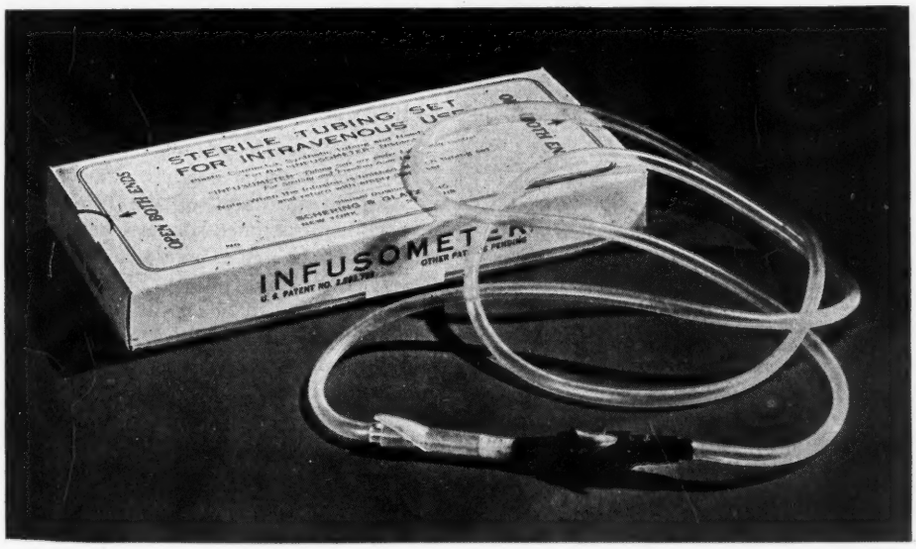
1) Puncture diaphragm 1 then insert air-vent needle at diaphragm 2.

2) Inject desired medication at diaphragm 3 of 'Infusometer' Dispenser.

3) Plug in plastic tubing connector at diaphragm 1, above dripmeter.



4) Invert and suspend assembled 'Infusometer' Dispenser. Note dripmeter *inside* neck of flask.



5) *Disposable,* sterile, all-plastic 'Infusometer' Tubing Set for use with 'Infusometer' Dispenser. *Trademark Reg. U. S. Pat. Off.

Sterile, pyrogen-free solutions in 'Infusometer' Dispensers with disposable 'Infusometer' Tubing Sets are available as a research service from the 'Sterisol' Division of

Schering & Glatz, Inc. *a subsidiary of*
WILLIAM R. WARNER & CO., INC., 113 West 18th Street, New York 11, N. Y.

Rochester Sets Up Ration Plan for Private Duty Nurses

In order to distribute private duty nurses to patients on the basis of need rather than the ability to pay, a new nursing service plan has been adopted by hospitals in Rochester, N. Y.

No private duty nurse can be employed in any member hospital of the Rochester Hospital Council unless the attending physician attests in writing as to the need for her services in each case. If her service is necessary, the physician must then apply to the nursing department of the hospital. A reference committee will be set up in each institution to decide the merits of each case.

When private duty nurses have been employed for special patients, they may be transferred to the care of other patients whose need is more urgent in the opinion of the nursing department. Such transfers from one case to another are also subject to review by the nursing committee.

Council Elects Officers

Mrs. Harry Hart, president of Women's and Children's Hospital, Chicago, was elected chairman of the board of directors of the Chicago Hospital Council at its annual meeting held recently. Dr. Herman Smith, superintendent, Michael Reese Hospital, was elected president; Rev. John W. Barrett, diocesan director of Catholic hospitals, was elected vice president, and Rupert Barry, member of the board of directors of Henrotin Hospital, was elected secretary-treasurer.

Nurses' Residence Opens

Galesburg Cottage Hospital, Galesburg, Ill., opened its new nurses' home recently. The home was made possible by a federal grant and on March 15, the hospital was advised that an additional grant of $48,325 would be made by the F.W.A. to add two more stories to the new structure. This will make it possible to move the student nurses out of the hospital building and provide space for 40 more hospital beds. The total cost of the new home will be $198,709.

Bulletin Changes Format

As it started its second volume, the *Bulletin* of the American Society of Hospital Pharmacists was transformed from a small mimeographed publication to a larger and more formal planographed magazine. The January-February issue which reached members about March 20 contained 28 pages and several long articles. The steady growth of the A.S.H.P. is indicated by the names of 45 new members contained in this issue. Drawings and photographs are included in the new form, which was not possible in the old bulletin.

Badge for Medical Men

The War Department has authorized a silvered metal medical badge to be awarded members of the medical department assigned or attached to the infantry who have rendered satisfactory service during combat. The badge is elliptical in shape with the caduceus and the Geneva Cross superimposed on a litter surrounded by a wreath of oak leaves. Enlisted and officer personnel below field grade is eligible for the badge; it may also be awarded to the regimental surgeon regardless of rank.

Birth Certificates Urged

WASHINGTON, D. C.—Only 92.5 per cent of current births are registered, the Children's Bureau announced on March 7 in urging doctors and all health workers to emphasize the slogan of this year's Child Health Day, "A Birth Certificate for Every Baby in the U.S.A." Child Health Day is May 1.

Union Workers Seek Health Care Benefits

Increased union activity in the health field was indicated by two events of March. The Pocketbook Workers Union of New York in cooperation with its employer group and 269 independent employers provided hospital and surgical indemnity benefits for more than 9000 pocketbook and leather goods novelty workers through Associated Hospital Service of New York. The entire cost will be paid for by the manufacturers.

John L. Lewis proposed for the United Mine Workers that a royalty of 10 cents per ton be levied against every ton of coal mined by his unions to provide "modern medical and surgical service, hospitalization, insurance, rehabilitation and economic protection." At time of going to press this proposal was still being negotiated by the unions and the mine operators.

Inclusive Rate Plan a Success

An inclusive rate program put into effect last July at New York Hospital, New York City, has had beneficial results for both the hospital and the patient, Dr. John B. Pastore, assistant superintendent, stated at the close of a survey completed recently. The program, under which patients pay a uniform daily price and receive the use of hospital facilities normally billed as extras, was devised thirteen years ago by University Hospitals in Cleveland and Evanston Hospital, Evanston, Ill. New York Hospital is the first in Manhattan to adopt the plan for all patients, although three institutions offer inclusive rates for ward and semiprivate patients.

Summer Course Announced

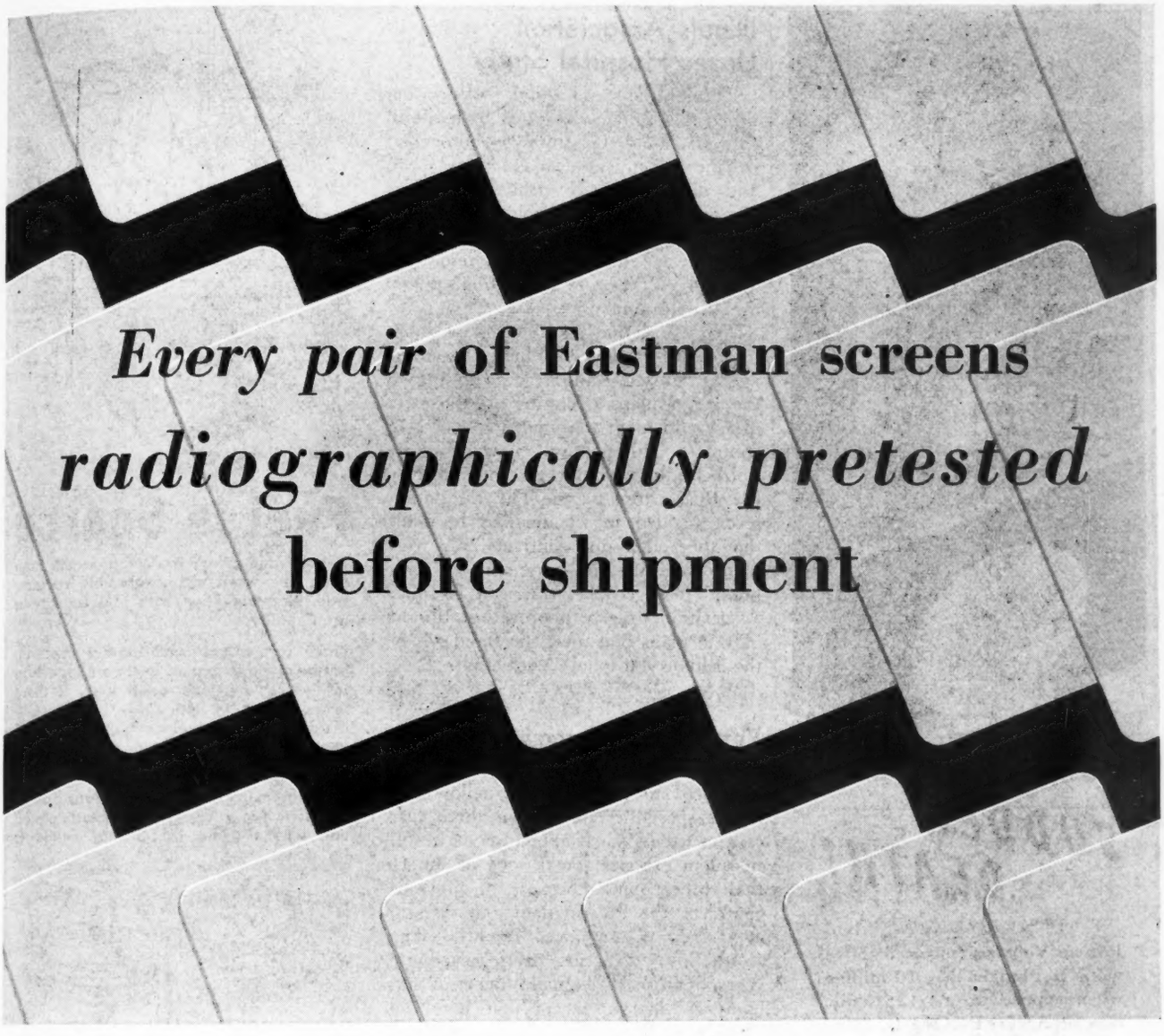
The summer school session at Syracuse University, to be held from July 23 to August 11, will include a course for graduate nurses on the "Teaching of Social and Health Concepts of Nursing Throughout the Basic Nursing Curriculum." It will be taught by Irene Carn, associate professor in the department of nursing at Skidmore College of Nursing. It is expected that funds for scholarships and maintenance for students will be available through the Division of Nurse Education of the U. S. Public Health Service. Information regarding the course can be obtained from the office of the dean of the school of nursing at Syracuse.

Veterans Facility Opens

On March 16, the first contingent of veterans entered the new facility of the Veterans Administration at Fort Washington, Md. The group was made up entirely of domiciliary members who were able to perform small duties for themselves, but it is expected that very shortly the facility will be prepared to receive male veterans requiring hospital service care and female veterans who may or may not require hospital care. Eventually the facility at Fort Washington will have approximately 1300 domiciliary beds, 65 hospital beds and accommodations for 80 women veterans.

Train Therapists in Plastics

Student therapists from Army hospitals are now training at the Plastic Model School at the Ordnance School, Aberdeen Proving Ground, Md. One of the first of its kind developed in the Army, the school is devoted to convalescent therapy. The students, both soldiers and Wacs, are learning the methods of working in plastics in the Army Service Force's program of visual aids for training ordnance technicians in the repair of complicated mechanical equipment. On the completion of their training, the students will return to their stations to instruct convalescent combat veterans in their work.



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There's no extra charge for this extra assurance of radiographic quality. Eastman absorbs the cost of pretesting; there is no advance in prices. In fact, the formerly more costly Ultra-Speed screens are now priced the same as other Eastman types.

3 Types *Ultra-Speed:* highest speed compatible with excellent definition . . . *Fine-Grain:* the general-purpose screen; "average" speed, greater detail . . . *High-Definition:* maximum detail, with only about 40% more exposure than Fine-Grain. Outstanding performance at high kilovoltage.

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Illinois Association Urges Hospital Study

The Illinois Hospital Association urged that a statewide study be made in Illinois along the lines recommended by the Commission on Hospital Care and directed its government relations committee to take suitable steps to see that such a study is inaugurated. This action was embodied in a resolution adopted at the state association's meeting in Springfield.

The association also took steps looking toward a statewide Blue Cross coverage by adopting and recommending to the seven plans operating in the state a new and more comprehensive form of contract. This follows closely the national uniform contract recommended by the Blue Cross plans. The association recommended to its member hospitals that they enter into contracts only with plans offering the recommended program. It urged the American Hospital Association to give approval in Illinois only to plans that meet the standards of the Illinois Hospital Association.

Veteran Appointments Allowed

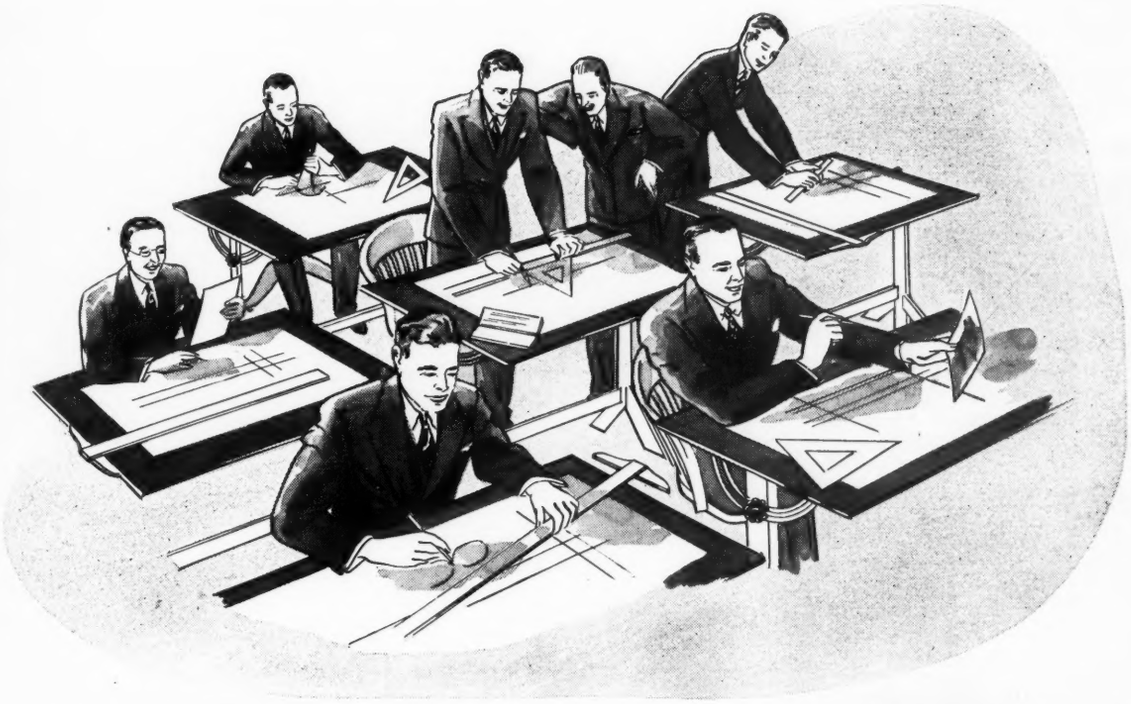
Physicians who are veterans may be appointed to residencies or fellowships in the specialties for two or three year courses even if such appointments result in quota excesses for periods of longer than nine months because of previous contracts, the Procurement and Assignment Service announced recently. The same thing is true of regular one year (nine month) appointments of veterans as interns, except that here the excess over the quota must not continue for more than nine months. Each request for appointment for such an excess-quota veteran must be sent by the hospital to the state chairman for transmission to the central P. & A. S. office for official approval.

Wisconsin to Make Survey

At the instigation of the Wisconsin Hospital Association, the governor has approved the idea of a statewide hospital survey and has instructed the commissioner of health to draft the necessary legislation appropriating $25,000 for the study. The hospital representatives met the governor recently.

Cincinnati Hospital Renamed

Hamilton County Tuberculosis Hospital in Cincinnati has been officially renamed Dunham Hospital, in memory of Dr. H. Kennon Dunham who served as medical director for twenty-seven years and was president of the board of trustees until his death several months ago.



Let TROY help you in planning your POST-WAR LAUNDRY

MORE EFFICIENT and more economical will be the post-war hospital laundries planned for and equipped with Troy's newest laundry machinery. A million dollars have been spent by Troy research laboratories to improve post-war laundry methods and machinery. The benefits of this research and of Troy's long, successful experience in the preparation of plans, layouts and specifications for all sizes of laundries are available to hospital executives and their architects without cost or obligation.

There are new and better answers to the problems of power and labor conservation, machinery arrangement, floor space limitations, provision for future expansion and other factors of laundry planning. Feel free to call in a specially trained Troy Sales Engineer from your nearby Troy sales office. Do it while your plans are in the early stages of development.

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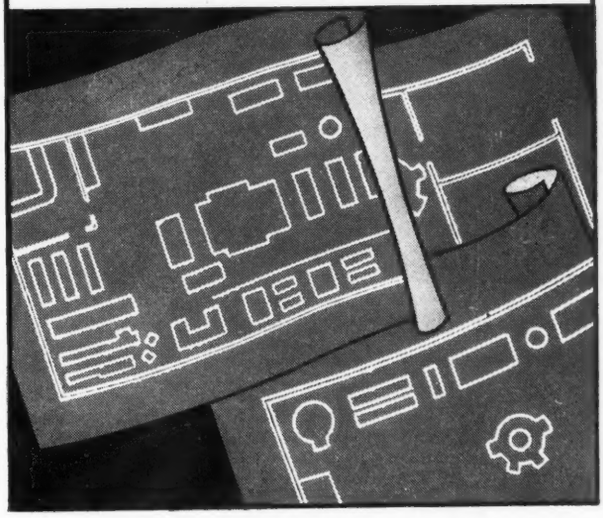

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DALLAS
Mercantile Bank Bldg.

CLEVELAND
1211 Leader Building

KANSAS CITY
Midland Building

PHILADELPHIA
12 So. 12th St.

DETROIT
7328 Hamilton Blvd.

HARTFORD
967 Farmington Ave.
W. H.

PITTSBURGH
732 Frick Building

SEATTLE: 2335 5th Avenue

ABOUT PEOPLE

(*Continued From Page* 80)

at Columbus, Ohio, has been named purchasing agent at Aultman Hospital, Canton, Ohio.

Miscellaneous

Dr. Natale Colosi, professor of bacteriology and public health at Wagner College, Staten Island, N. Y., and director of Parkway Hospital, New York City, has been appointed a member of the New York Commission of the Interstate Sanitation Commission by Gov. Thomas E. Dewey. Doctor Colosi is a fellow of the American Public Health Association and a member of the teaching staff of the extension division of Hunter College.

W. Crane Lyon, former executive secretary of Hospital Council, Inc., Newark, N. J., will represent Young and Meyers, New York City, in providing a public relations service to a limited number of hospitals.

Col. Ira V. Hiscock, professor of public health on leave of absence, who is now serving as chief of the public health section of the Civil Affairs Division of the War Department, will succeed **Prof. Charles-Edward Amory Winslow** as chairman of the department of public health at Yale University. Professor Winslow is retiring at the end of the academic year after thirty years of service on the Yale faculty.

Dr. J. R. McGibony, director of health, U. S. Office of Indian Affairs, will be transferred on April 15 to the hospital facilities section of the United States Public Health Service in Washington, D. C., which is headed by Dr. Vane M. Hoge. Doctor McGibony will be succeeded as director of health by **Dr. Ralph B. Snavely,** who also is a commissioned officer of the U.S.P.H.S. During his period in the service Doctor Snavely has been assigned to foreign duty, has been executive officer of the Marine Hospital in New York City, has been a hospital administrator in the Office of Indian Affairs and most recently was a district medical director of the Indian Service in San Francisco and Albuquerque.

Mrs. Estelle Massey Riddle has been appointed to the faculty of the department of nursing education at New York University. Mrs. Riddle, who was formerly superintendent of nurses at Homer G. Phillips Hospital, St. Louis, president of the National Association of Colored Graduate Nurses, Social Explorer for the Julius Rosenwald Fund and is at present a consultant on the staff of the National Nursing Council for War Service, will begin her new duties with the spring semester.

Thomas A. Hendricks, since 1924 executive secretary and head of the bureau of publicity of the Indiana State Medical Association at Indianapolis, has joined the staff of the A.M.A. on a part-time basis as secretary of the council on medical service and public relations with headquarters in Chicago. Mr. Hendricks has been managing editor of the state medical journal for the last ten years.

Deaths

John R. Morris, business manager and assistant superintendent at Paterson General Hospital, Paterson, N. J., died at the age of 68. Prior to his association with the hospital, Mr. Morris was registrar of deeds and mortgages for Passaic County, New Jersey.

Joseph P. Brady, superintendent of Bayonne Hospital and Dispensary, Bayonne, N. J., for the last six years, died recently at his home at Bayonne.

Dr. William J. Ellis, commissioner of the New Jersey State Department of Institutions and Agencies since 1926, died recently at his home on the grounds of the Trenton State Hospital, Trenton. He was 53 years old.

OFFICIAL ORDERS
February 15 to March 15

Chinaware.—No increase in packaging charges for vitrified chinaware will be granted, O.P.A. announced on March 12 after a thorough examination of financial data. The current over-all earning position of the industry is superior to normal peace-time earnings, O.P.A. said.

Coal.—A priority list that can be used if necessary to channel coal to essential war and civilian users was announced by W.P.B. on March 7 at the request of the Solid Fuels Administrator for War. The minimum requirements of hospitals are in Class 3, following the needs of plants that would suffer irreparable damage to equipment by a coal shortage (Class 1) and ships, railroads and public utilities (Class 2). There are seven classes in all.

Communicating Systems.—The restriction on the use of blanket M.R.O. priority ratings to obtain electronic intercommunicating systems applies only to getting new systems, not to obtaining repair parts or extending an existing system to its full capactiy, W.P.B. announced on February 27.

Fuel Oil.—There will be no further issuance of fuel oil rations for use in space heaters that furnish heat or hot water in nonresidential premises, O.P.A. announced on February 26. This rule applies in cases where the ration would be 10,000 gallons or more in a year.

Gasoline Rations.—More specific requirements for supplemental gasoline rations for volunteer workers were announced by O.P.A. on March 5. Probably hospital volunteers are included under the category of essential social service agencies. Governmental units that contribute to the general welfare are also included in this category.

Ice Boxes.—Specific ceiling prices for a limited quantity of steel ice boxes were established on March 1 by O.P.A. for the 19 models to be constructed this year. Average retail prices range from $37.50 to $67.50. W.P.B. authorized the manufacture of 75,000 ice boxes in the first quarter but only part of them were constructed of steel.

Asociates Honor Dr. Henry M. Pollock

A testimonial luncheon, which was attended by nearly 150 persons, was tendered on March 10 to Dr. and Mrs. Henry M. Pollock. Doctor Pollock has retired as administrator of Massachusetts Memorial Hospital, Boston, which he headed since 1915. He entered hospital administrative work in 1899 when he became assistant superintendent of Norwich State Hospital, Norwich, Conn. In 1904 Doctor Pollock became superintendent of that institution and remained in that capacity until 1915. For twenty-one years he was associate commissioner of the Massachusetts Department of Mental Diseases.

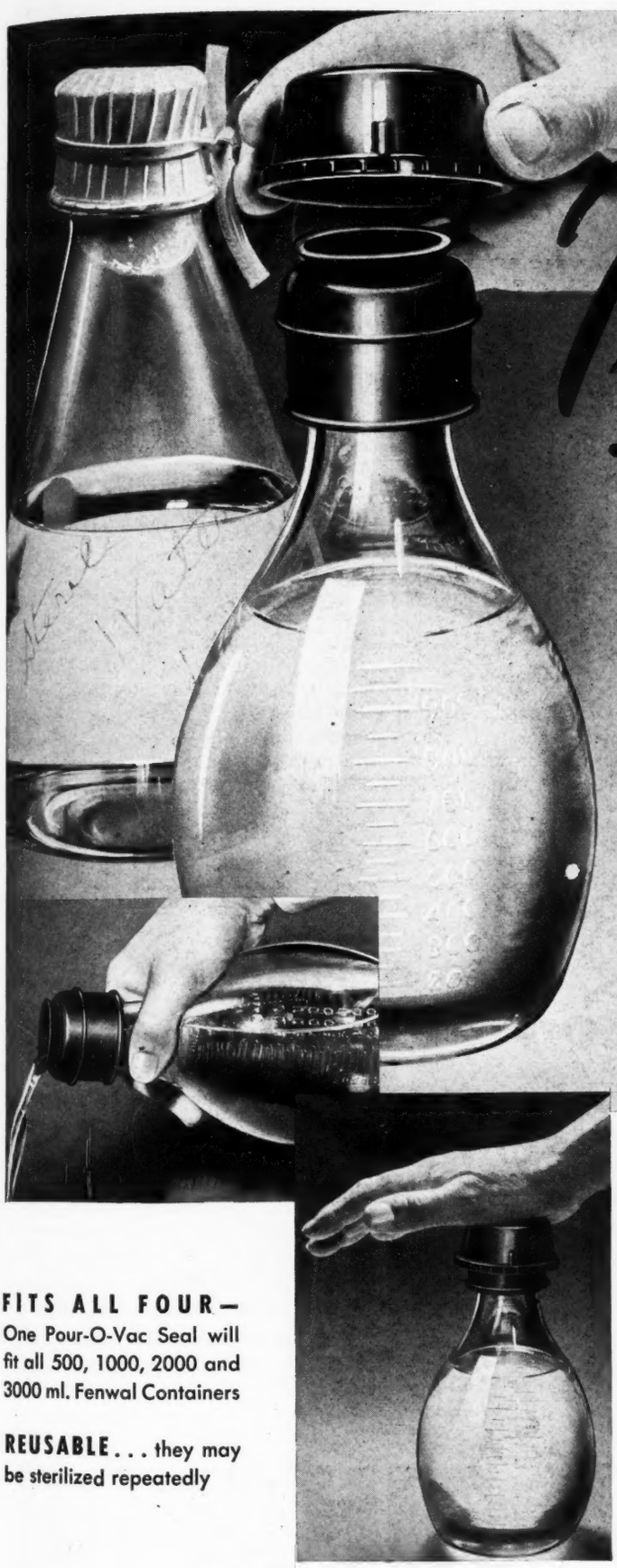
Speakers at the luncheon included Dr. Donald C. Smelzer, A.H.A. president, Everett W. Jones, The Modern Hospital, and Dr. C. F. Wilinsky, director, Beth Israel Hospital, Boston, who made the gift presentation talk. Doctor and Mrs. Pollock were presented with a check for $350. Dr. James W. Manary, superintendent of Boston City Hospital, was the toastmaster.

Physical Therapists Needed

The National Foundation for Infantile Paralysis has appropriated $1,267,600 for the training of urgently needed physical therapists to care for infantile paralysis victims. In announcing the program, Basil O'Connor, foundation president, states: "It is estimated that an additional 5000 physical therapists could be used right now, not only for the treatment of infantile paralysis, but also for aiding recovery from many other diseases and disabilities." The program will include scholarships to train new physical therapists and fellowships to provide additional teachers.

Philadelphia Hospital Closed

Kensington Hospital for Women, Philadelphia, closed recently because of financial difficulties and the shortage of nurses. The functions of the 101 bed hospital, as well as three resident physicians and 15 staff doctors, have been transferred to the Hospital of the Protestant Episcopal Church. Dr. Lucius R. Wilson is superintendent of both institutions.



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HIGHLIGHT FEATURES INCLUDE—

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FITS ALL FOUR—
One Pour-O-Vac Seal will fit all 500, 1000, 2000 and 3000 ml. Fenwal Containers

REUSABLE . . . they may be sterilized repeatedly

A TIME AND MONEY SAVER, TOO!

Eliminates waste of unused or out-dated solutions.

No time-consuming or wasteful use of gauze, paper, string or tape.

Protects lips of containers against chipping or breakage.

Nurses will welcome the ease and simplicity with which sealing, unsealing and handling are accomplished.

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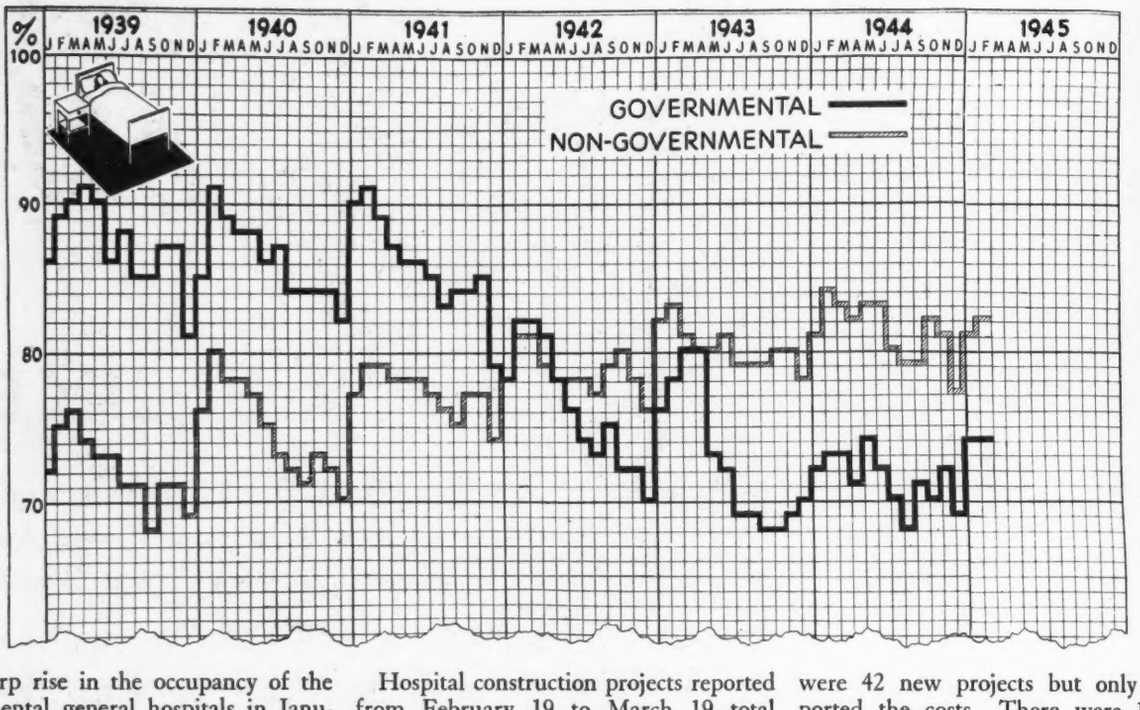
Occupancy in Governmental Hospitals Rises



A sharp rise in the occupancy of the governmental general hospitals in January and February and a somewhat smaller rise for the nongovernmental general institutions are recorded on the basis of preliminary figures. The former already exceeds last year's level.

Hospital construction projects reported from February 19 to March 19 total $9,019,000. This brings the year to date figure to $30,729,000 as compared with $24,843,000 for the same period of last year.

In the four weeks under review, there were 42 new projects but only 34 reported the costs. There were 10 new hospitals and allied institutions, 25 additions to existing institutions, five alterations and two new nurses' homes. Additions continue to constitute the largest form of hospital building.

What's New for Hospitals

APRIL 1945 SUPPLEMENT TO THE MODERN HOSPITAL AND THE HOSPITAL YEARBOOK

Continuous Caudal Analgesia Outfit

Several improvements have been made in the equipment for continuous caudal analgesia developed by Becton, Dickinson and Company in cooperation with Doctors Hingson and Edwards. The improved outfit, No. 441, is supplied with hose hub needle made so that it can be attached directly to the bottles of anesthetic solutions now on the market, thus doing away with the need for transferring the solution to a flask.

This outfit has a new safety caudal needle with a safety bead to guard against the possibility of breakage at the hub. The needle is malleable and may be bent without danger of breakage. The syringe plunger is longer so it need not be withdrawn as far as the ordinary syringe plunger, thus minimizing the danger of infection. Elimination of the valve in favor of a stopcock simplifies the operation and makes the outfit less subject to mistakes and lost parts during handling and cleaning. **(Key No. 2515)**

Becton, Dickinson & Co., Dept. MH, Rutherford, N. J.

Improved Suture Package

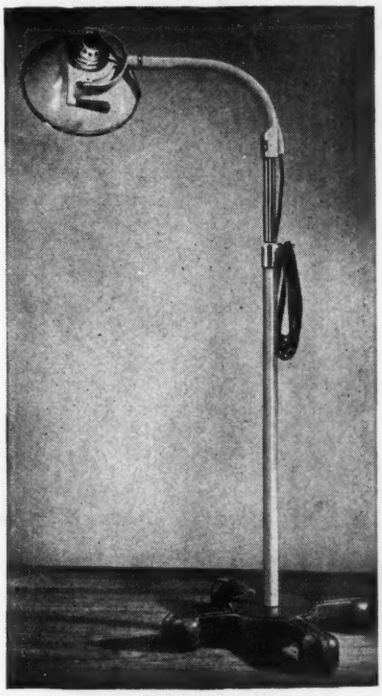
Packages for Ethicon sutures have been redesigned for quicker and easier selection of the particular suture desired. A yellow border immediately identifies the package containing non-boilable sutures while the package containing boilable sutures is designated by a blue border. The type, size and code are plainly marked on both top and side labels and the type faces used on the labels have been carefully selected for maximum clarity. **(Key No. 2563)**

Ethicon Suture Labs., Dept. MH, New Brunswick, N. J.

Specialist's Light

A light especially designed for operations, examinations, treatments and similar work has been announced as the No. 46 Specialist's Light. It has an offset arm which extends approximately 20 inches over the working area and the lamp head rotates by means of a tilting handle so that it can be focused at will. A telescope tube permits vertical adjustment from 48 to 75 inches in height. The upright of the light is internally counterbalanced so that no manual locking device is necessary to hold it at the desired height.

The 44 pound base ensures against the possibility of tipping and a cord hook is



provided to hold the 20 feet of cord when not in use. **(Key No. 2598)**

Wilmot Castle Co., Dept. MH, Rochester 7, N. Y.

Clinitest Pocket-Size

Clinitest, the fast, simple method for determining urine-sugar, is now available in a small, compact pocket size. All essentials for testing are fitted into a small, durable plastic kit about the size of a cigarette package. The kit contains 36 Clinitest tablets with instruction sheet and analysis record, Clinitest dropper and color scale. **(Key No. 2519)**

Ames Co., Inc., Dept. MH, Elkhart, Ind.

"Dairy" Orange Juice

A new source of orange juice is being offered by Green Spot, Inc. The juice is extracted, condensed and shipped in refrigerated cars to dairies throughout the country. Pure water is added to restore it to original juice consistency and the product is delivered by the dairies in quart bottles with regular milk deliveries.

The cost of a quart of orange juice delivered in this manner is less than buying fresh fruit and extracting the juice. In addition, there is no waste disposal or spoilage. The juice is kept ice cold from the time the oranges are squeezed until it is delivered to the hospital by the dairy thus preserving the taste of fresh ripe fruit. Arrangements have been made with some hundreds of dairies throughout the country to handle this product. **(Key No. 2522)**

Green Spot, Inc., Dept. MH, Los Angeles, Calif.

Laboratory Animal Food

A new food for laboratory animals has been developed by Ralston Purina and offered under the name Purina Laboratory Chow. It is a complete ration for rats, mice, hamsters and dogs. For cats, only meat or meat juices are needed as a supplement and vitamin C for monkeys. The usual quantity of drinking water should be given.

Ingredients of Purina Laboratory Chow are checked for chemical, mineral and vitamin content and the food is handled so that it is fresh when delivered. It is made in squares and is clean, easy to handle and easy to feed, leaving very little waste. The composition of this food is constant and therefore desirable for experimental work requiring uniform dietary history. **(Key No. 2575)**

Ralston Purina Co., Dept. MH, Checkerboard Square, St. Louis, Mo.

Latex Foam Mattress

A new latex foam has been developed by Hewitt Rubber Corporation and will soon be available in mattresses. This new synthetic foam rubber is known as Restfoam and is fire-resistant, washable and odorless. It can be produced in colors and will have other uses when released for civilian needs. **(Key No. 2576)**

Hewitt Rubber Corp., Dept. MH,Buffalo, N. Y.

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

Butter Flavor

Freeman's Imitation Butter Flavor is a new product developed to improve the flavor of cooked and baked foods. It is easily mixed into margarine or shortening with an electric mixer and does not cook out. Money and points are saved by the use of this product which needs no refrigeration, does not turn rancid and will not change the color of margarine or shortening.

If the product is used in margarine for table service, notice of the use of a butter substitute is required but this is not necessary when it is used only in cooking and baking.

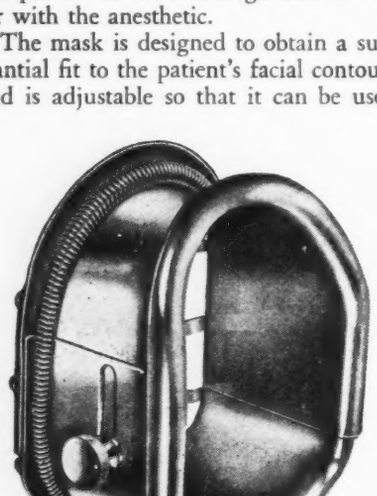
The Sexton organization is exclusive distributor of this product which is manufactured by Freeman Food Products Co., Chicago. **(Key No. 2620)**

John Sexton & Co., Dept. MH, P. O. Box JS, Chicago

Adjustable Anesthetic Mask

The new Greenblum Adjustable Anesthetic Mask, known as the GAAM Mask, was designed by Dr. Louis L. Greenblum to allow more convenient and effective administration of all drop method and spray anesthetics. The mask is chrome plated, with no cushions or pads, and permits thorough and frequent sterilization. Gauze is placed over the flat surface when the mask is in use and is secured by a closely wound spiral spring. It can be easily applied or removed and the large open area permits the patient to breathe large amounts of air with the anesthetic.

The mask is designed to obtain a substantial fit to the patient's facial contours and is adjustable so that it can be used



for children or lengthened for adults. Its shape keeps it in place when adjusted to fit the patient. **(Key No. 2415)**

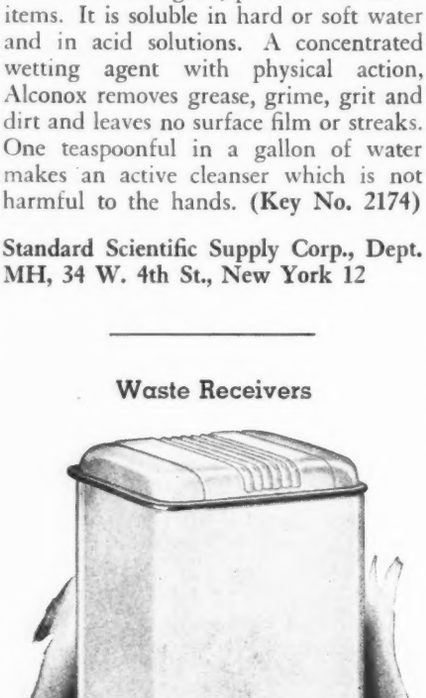
J. Sklar Mfg. Co., Dept. MH, 38-04 Woodside Ave., Long Island City, N. Y.

Cleanser

Alconox is an all purpose cleanser especially developed for use in cleaning hospital utensils, laboratory ware, glassware and other glass, porcelain or metal items. It is soluble in hard or soft water and in acid solutions. A concentrated wetting agent with physical action, Alconox removes grease, grime, grit and dirt and leaves no surface film or streaks. One teaspoonful in a gallon of water makes an active cleanser which is not harmful to the hands. **(Key No. 2174)**

Standard Scientific Supply Corp., Dept. MH, 34 W. 4th St., New York 12

Waste Receivers



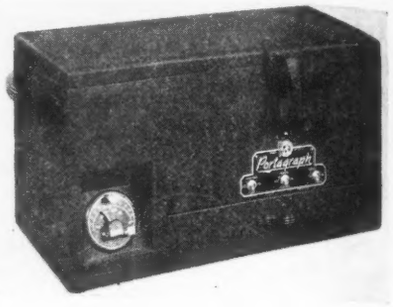
Two new waste receivers, one with a closed and one with an open top, have been announced. Made of steel with white enamel finish and a black base, the receptacles have a removable can inside for convenient handling. Paper bags can be used for the waste.

The closed top receptacle has a rubber silenced cover which is foot operated. The opening in the open top type is 5¾ inches square and the top is finished in black. It can be lifted off for easy removal of the waste filled paper bag. Both receivers are 10 inches square and 24 inches high. **(Key No. 2571)**

Hamilton Mfg. Co., Dept. MH, Two Rivers, Wis.

Improved Portagraph

The improved Portagraph, for making copies of anything written, printed or drawn, has many changes which give it better appearance while providing more convenient and economical operation. The new model has a convenient, recessed position for the improved timer, a handy roll paper container at the end



of the glass contact plate for more economical handling of odd size forms, a new lighting assembly controlled by convenient switches, heavier and more durable hinges, a paper protector and harder and heavier handle rollers. It is made entirely of steel and streamlined for efficient operation.

The Portagraph permits the making of accurate copies, either from sheets or from bound books, within a few minutes. No additional equipment or dark room is needed and the outfit can be operated without specialized training or experience. **(Key No. 2483)**

Remington Rand Inc., Dept. MH, Buffalo 5, N. Y.

Dustproofing Liquid

A new ready-prepared liquid has been developed as a dustproofing treatment for terrazzo and concrete floors. Applied with a mop, brush, broom or sprayer, "Westkrete" dries quickly and seals the floor against water, oils and chemicals. The product does not easily wear off under traffic and can be applied over painted or worn surfaces without affecting the appearance of the floor. It soaks into porous cement and penetrates below the surface, hardening to a rocklike mass. **(Key No. 2417)**

E. F. Westfield Co., Dept. MH, 333 Sixth Ave., New York 14

Steam Mixer Water Heater

The new O'Brien Steam Mixer Water Heater is a complete packaged unit, compact and easy to install. It includes heater, temperature regulator, temperature-pressure relief valve, thermometer and, where necessary, water pressure regulator and steam and water pressure gauges.

There is no waste of condensate and no condensation return system is required as the heat of the steam is de-

livered to the water and the condensate is utilized as hot water. The unit is easily installed near the point of use to deliver an adequate supply of hot water at controlled temperatures. A wide selection of temperature ranges makes the unit practical as a primary or booster heater. It is designed for steam pressures of 50 to 150 pounds. **(Key No. 2426)**

O'Brien Steam Specialty Co., Dept. MH, 205 Harrison St., Syracuse 2, N. Y.

"Slimline" Fluorescent Lamps

The General Electric Company has announced a new line of four extremely thin fluorescent lamps to provide equipment for all lighting needs. The longest unit measures one inch in diameter and nearly eight feet in length, with another one inch lamp six feet long. In addition there are two ¾ inch diameter sizes, one 3½ feet long and the other slightly more than 5 feet in length. All of the lamps are of the instant starting type. **(Key No. 2482)**

General Electric Co., Dept. MH, Nela Park, Cleveland, Ohio

"Soapless Soap"

"QXL" is the name of a new liquid cleaner which is instantly soluble in the hardest water as well as in salt water. It is free from corrosives, harmless to hands or clothing, but potent and effective in cleaning. It softens the water and by wetting out, emulsification and dispersion promptly removes all dirt or grime. It is nontoxic, free from alkali, lye or abrasives and can be used for cleaning kitchen equipment, textiles, walls and floors. **(Key No. 2418)**

Technical Development Labs., Dept. MH, Tenafly, N. J.

Box Trucks

The new Monarch box trucks for use in transporting materials and supplies in the hospital are available in all standard sizes. They are made from hardened fiber and seasoned lumber with reenforcements of solid oak ribs joined by custom-made hardware. The trucks are mounted on five inch free wheeling casters with rubber tires to make them noiseless and efficient and are available in open side or drop side types. **(Key No. 2422)**

Standard Holloware Corp., Dept. MH, Whitestone, N. Y.

PHARMACEUTICALS

Bornex

A new product for the eradication of head, crab and body lice has been announced under the name Bornex. It is water miscible, noninflammable, nonirritating and usually kills nits and lice in a single treatment. It readily penetrates the thickest hair and is free from greasiness, staining or unpleasant odor. Bornex is packaged in gallon bottles for institutional use. **(Key No. 2583)**

Wyeth Inc., Dept. MH, 1600 Arch St., Philadelphia 3, Pa.

Vonedrine Inhaler

A new plastic inhaler containing 250 mg. Vonedrine in combination with small amounts of aromatics has been developed for use with acute rhinitis, acute sinusitis, vasomotor or allergic rhinitis and nasal congestion resulting from upper respiratory disease of any nature. It is attractively designed and presented in gray and white plastic. Research indicates that there are no untoward effects from the use of the inhaler. Its freedom from toxicity and from nervous reactions indicates that it may be used frequently to maintain nasal patency. **(Key No. 2524)**

Wm. S. Merrell Co., Dept. MH, Cincinnati, Ohio

Thromboplastin

Thromboplastin was developed for use as a means of aiding in establishing the diagnosis of hypoprothrombinemia. It is a preparation obtained from an aqueous extract of fresh beef lung, dried by a special technic and sealed in vacuum to insure stability. Each ampule contains an amount that, when added to normal human blood, gives the clotting time in fifty seconds or less. It is supplied in 3 cc. size ampules. **(Key No. 2431)**

Upjohn Co., Dept. MH, Kalamazoo 99, Mich.

Hykinone

Hykinone, 60 mg. is the trade mark adopted by Abbott Laboratories for Menadione Bisulfite. It is an aqueous solution made isotonic with sodium chloride and is used as an antidote for the hypoprothrombinemia caused by Dicumarol overdosage. It is supplied in three 10 cc. ampules for intravenous administration. **(Key No. 2432)**

Abbott Laboratories, Dept. MH, North Chicago, Ill.

RECENT CATALOGS AND BOOKLETS

• Full information on the indications, contraindications, methods of administration, cultural characteristics, history and other details of Penicillin is included in a booklet issued by Schenley Laboratories, Inc., 350 Fifth Ave., New York 1, entitled **"Penicillin, Its Development and Therapeutic Application."** A chart showing administration and dosage of Penicillin is included. **(Key No. 2606)**

• A 16 mm. sound motion picture entitled **"Oxygen Therapy Procedures,"** offering helpful teaching material for nurses, interns and even doctors as well as other personnel concerned with oxygen therapy, has been prepared by the Linde Air Products Co., 30 E. 42nd St., New York 17. It is designed to fill the need for comprehensive instruction material on the mechanical phases of oxygen administration and depicts many different types and makes of oxygen therapy apparatus. Safe practices in oxygen administration are demonstrated and the operation of intranasal oropharyngeal catheters, face masks and oxygen tents is described in detail. The film has been approved by the American College of Surgeons Committee on Medical Motion Pictures. It has a running time of 35 minutes and should prove valuable to any hospital offering nurse or intern training and to nonteaching institutions as a review for the professional staff. **(Key No. 2635)**

•Clinical indications, administration and dosage of **Lipo-Lutin,** a solution of progesterone in oil for treatment of corpus luteum deficiency, are included in a brochure prepared by Parke, Davis & Co., Detroit 32, Mich. **(Key No. 2601)**

• Uses of the **"Berman Metal Locator,"** the instrument which locates foreign bodies so that they can be quickly removed by surgery, are described and illustrated in a booklet issued by Waugh Laboratories, 420 Lexington Ave., New York 17. **(Key No. 2548)**

• The seven basic types of fire extinguishers in everyday use are described and illustrated in a folder entitled **"Your Fire Protection Insurance Policy."** Issued by the General Detroit Corp., 2270 E. Jefferson Ave., Detroit 7, Mich., the folder also gives information on the classes of fire each extinguisher is designed to combat most effectively. **(Key No. 2546)**

• **"From Sweet Clover to the Prevention of Thrombosis"** is the title of a pamphlet issued by Ayerst, McKenna & Harrison Ltd., Rouses Point, N. Y., containing information on Dicumarol. **(Key No. 2549)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

• The seventh edition of the helpful booklet, **"Vitamin Products for Prescription Use,"** published by Eli Lilly & Co., Indianapolis 6, Ind., is now available. **(Key No. 2605)**

• Another in the series of portfolios of anatomic illustrations drawn by Dr. Frank Netter and issued by Ciba Pharmaceutical Products, Inc., Summit, N. J., has just been released. This covers **"Major Pathology of the Duodenum"** and consists of twelve color plates portraying normal and pathological anatomy of the duodenum. **(Key No. 2610)**

• **"Little Man—What Now?"** is the title of an attractive booklet describing and illustrating the use of the Boren Plastic Bassinet. This practical, transparent bassinet, with convenient storage space as an integral part of the unit, is distributed by A. M. Clark Co., 329 S. Wood St., Chicago 12. **(Key No. 2630)**

• Details regarding **Larocal,** the new calcium wafer containing vitamins C and D and designed for oral calcium therapy, are given in a folder recently issued by Hoffmann-La Roche, Inc., Nutley 10, N. J. **(Key No. 2544)**

• **Catalog No. 161, Obstetrics,** contains descriptive information and illustrations of obstetrical manikins and charts available from Clay-Adams, Inc., 44 E. 23rd St., New York 10. **(Key No. 2553)**

• The story of the actual installation and use of a **TelAutograph** system in a large general hospital with resultant saving in personnel and supplies is told in a report prepared by the TelAutograph Corp., 16 W. 61st St., New York 23. **(Key No. 2542)**

• Administrative personnel interested in occupational therapy will find the new **catalog** recently issued by Fellowcrafters, Inc., 130 Clarendon St., Boston 16, Mass., worth some study. In addition to information on materials covering 20 crafts, the catalog includes a section of availability and priorities, the use of items listed and postage map and tables. **(Key No. 2609)**

• A booklet discussing **"Scientific Sizing and Flow Control in Grease Interception"** has been issued by Josam Mfg. Co., Empire Bldg., Cleveland. Charts illustrating installations of grease interceptors are included together with illustrations of surgical and plaster sink interceptors. **(Key No. 2535)**

• **Bulletin No. 138** of the Spencer Turbine Co., Hartford 6, Conn., illustrates and describes their system of dry mop cleaning. This item should be of particular interest to the housekeeping and maintenance departments. **(Key No. 2536)**

• **"First Line of Health Defense"** is the title of a pamphlet issued by Hood Chemical Co., Inc., 1819 Broadway, New York 23. Full information on hospital uses of Hoodchlor, the general disinfectant, are included. **(Key No. 2539)**

• Information on **Turkel Trephine Instruments** for marrow infusions and biopsies is given in a pamphlet prepared by Trephine Instruments, Inc., 1302 Industrial Bank Bldg., Detroit 26, Mich. **(Key No. 2541)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

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- ☐ 2415 Adjustable Anesthetic Mask
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- ☐ 2426 Steam Mixer Water Heater
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- ☐ 2483 Improved Portagraph
- ☐ 2515 Continuous Caudal Analgesia Outfit
- ☐ 2519 Clinitest Pocket-Size
- ☐ 2522 "Dairy" Orange Juice
- ☐ 2524 Vonedrine Inhaler
- ☐ 2535 "Scientific Control in Grease Interception"
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- ☐ 2544 Larocal
- ☐ 2546 "Your Fire Protection Insurance Policy"
- ☐ 2548 "Berman Metal Locator"
- ☐ 2549 "Prevention of Thrombosis"
- ☐ 2553 Catalog No. 161
- ☐ 2563 Improved Suture Package
- ☐ 2571 Waste Receiver
- ☐ 2575 Laboratory Animal Food
- ☐ 2576 Latex Foam Mattress
- ☐ 2583 Bornex
- ☐ 2598 Specialist's Light
- ☐ 2601 Lipo-Lutin
- ☐ 2605 "Vitamin Products"
- ☐ 2606 "Penicillin"
- ☐ 2609 Catalog
- ☐ 2610 "Major Pathology of the Duodenum"
- ☐ 2620 Butter Flavor
- ☐ 2630 "Little Man—What Now?"
- ☐ 2635 "Oxygen Therapy Procedures"

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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc., 919 N. Michigan Ave., Chicago 11, Ill.

Manufacturers' Plant News

The Horton Intercoupler, a safety device used to reduce the hazard of igniting explosive anesthetic gases, has been taken over by the **Ohio Chemical and Manufacturing Company** and is being manufactured by the **Heidbrink Division,** 2633 Fourth Avenue South, Minneapolis, Minn. **(Key No. 2641)**

Faraday Electric Corporation of Adrian, Michigan, announces that its executive, sales and advertising offices are now located at 11 South La Salle Street, Chicago 3. Manufacturing continues at Adrian. **(Key No. 2642)**

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